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the West Virginia Medical Journal

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Vol. 61 No. 1

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98th Annual Meeting, The Greenbrier, August 26-28, 1965

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*Roseman, E.: *Neurology* **11**:912, 1961. 33664

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The West Virginia Medical Journal

January, 1965 Vol. 61, No. 1

Radiological Diagnosis of Bronchogenic Carcinoma

Harold I. Amory, M. D.

Carcinoma of the lung has assumed such proportions as a health hazard that efforts to detect it in its early stages must be accelerated.

Radiation in the form of roentgen rays is one diagnostic agent which is useful during all stages of the disease. It is the only means of detecting the lesion during the asymptomatic period which may last for many months or years. After symptoms and signs have appeared, roentgen rays have wide application in attempts to diagnose and accurately localize the lesion.

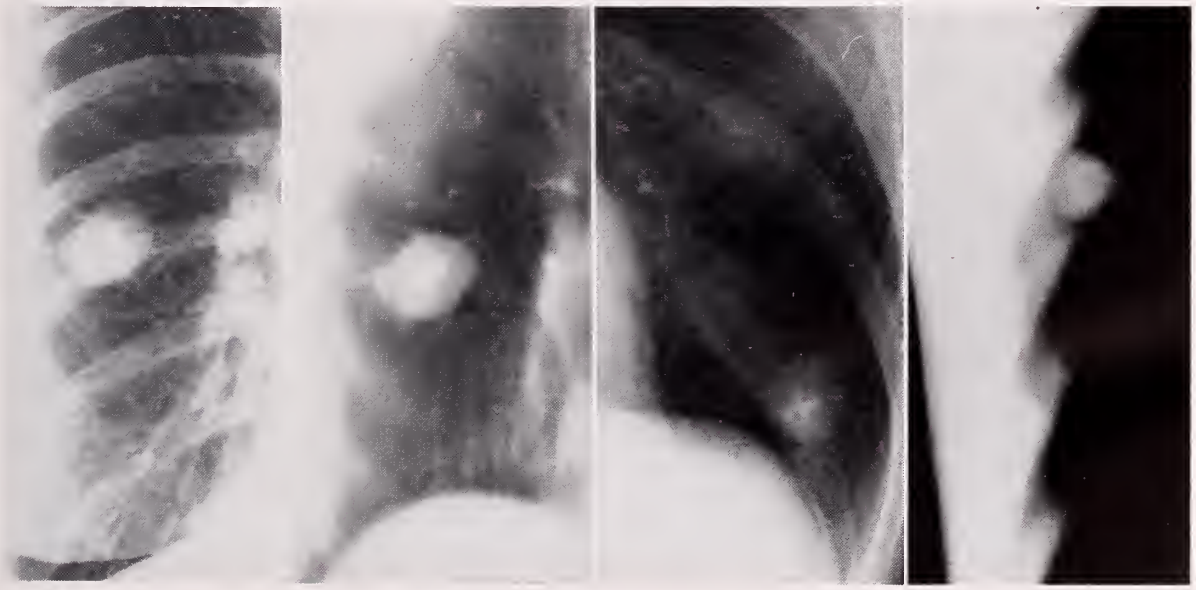
What is needed diagnostically to help combat this increasingly prevalent disease is a simple chemical or biological test which can be applied on a wide scale. Until such a test is developed, it is necessary to make full use of the tools now available.

Submitted to the Publication Committee, June 15, 1964.

The Author

- **Harold I. Amory, M. D., Professor and Chairman, Department of Radiology, West Virginia University School of Medicine, Morgantown.**

A reasonable solution to the diagnostic problem would appear to be some universal program of chest radiography similar to the highly successful tuberculosis surveys. Attempts toward this end, however, thus far have failed. In the Los Angeles area two million individuals were examined by photo-fluorography with a yield of 144 cases of primary cancer of the lung or 7.6



A B C D

Figure 1 (A)—Large peripheral lesion. Suspicion of central calcification suggesting granuloma. (B)—Laminagram demonstrates calcified center proving benignancy. Excision biopsy revealed histoplasmoma. (C)—Irregular calcification. Excision biopsy revealed a benign lesion. Hamartoma. (D)—Crescentric, ring, and shell calcification indicate granuloma. Exision biopsy revealed tuberculoma.

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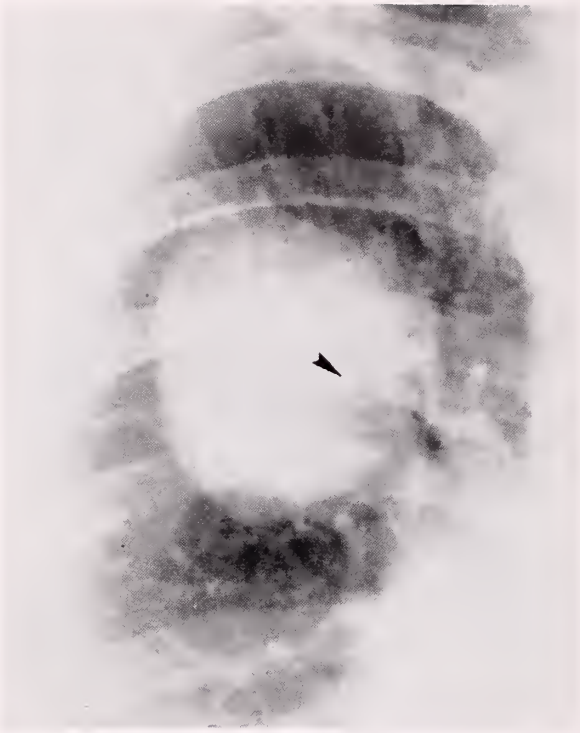


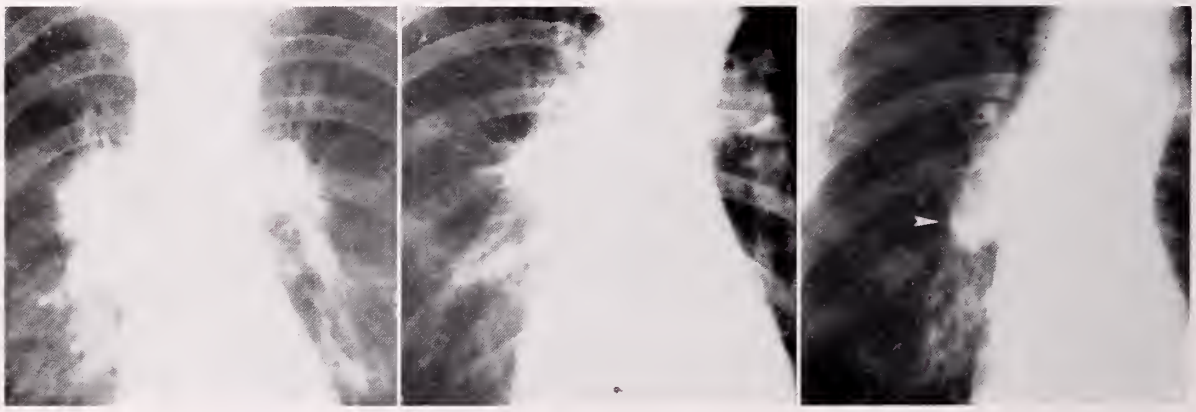
Figure 2. Umbilication, lower medial aspect, indicates malignancy. Leo Rigler.

cases per 100,000 persons. If this survey had been restricted to males over 45, the rate would have been 50 per 100,000. Forty-two per cent were found to be resectable and the short term curability rate was 11 per cent. It was concluded that this low salvage would not warrant the enormous effort required to examine millions of adults.[1] The practical approach seemed to be to examine by x-ray all patients entering hospitals and all who have chest symptoms of any nature. An irritative cough, with increasing mucoid expectoration, especially if blood tinged, is suggestive of carcinoma. A unilateral wheeze, repeated attacks of pneumonitis, pain, loss of weight, anorexia and hemoptysis are even more indicative. The growing custom of complete annual physical examination including chest films practiced by many organizations as a personnel policy should be encouraged and broadened. Although such limited coverage falls far short of a systematic search, the discovery of a large number of lesions will result.

The miniature film has generally fallen into disuse, chiefly because radiologists and other physicians prefer the full size 14″ x 17″ film. A lesion a few millimeters in diameter can be detected with 14″ x 17″ film while one less than 1 cm. is difficult to detect photofluorographically. An average bronchogenic carcinoma 1 cm. in diameter contains approximately 33,000,000 cancer cells and therefore cannot be considered an early lesion. A second disadvantage of photofluorography is the larger quantity of radiation necessary.[2]

In the study of chests for the detection of cancer, postero-anterior and lateral views using 14″ x 17″ film constitute the basic examination. These may be supplemented by oblique and apical lordotic views and by films made in inspiration and expiration if small zones of obstructive emphysema are to be detected. If the basic examination reveals a mass or an unexplained zone of infiltration, an intensive search for significant signs of carcinoma should be made. Fluoroscopy, bronchography, laminagraphy and angiography may be necessary for accurate localization and may help determine resectability.

Although roentgen signs of carcinoma of the lung are numerous and at times are masked by concurrent disease processes such as pneumoconiosis and tuberculosis, usually one or more definite changes have occurred and clear cut evidence can be detected by careful roentgen examination and interpretation. This report briefly



A B C

Figure 3 (A)—Typical primary right hilar carcinoma. Left hilus normal. (B)—Normal chest, April, 1959. (C)—January, 1963. Enlargement of lower pole right hilus as compared with film made four years previously (Figure 3 B). Primary carcinoma.

discusses the more important signs which are illustrated by cases encountered at the West Virginia University Medical Center.

The solitary spherical noncalcified pulmonary shadow often referred to as a "coin lesion" is frequently encountered and presents a problem of differentiation. If the lesion was not present on previous films, it is much more likely to be a carcinoma than a granuloma, especially in individuals past middle age. It is an indication for local resection or biopsy of the area followed by a more radical procedure if carcinoma is confirmed microscopically.

A peripheral, spherical pulmonary mass or nodule which shows an increase in size when compared with previous films is even more likely to be a carcinoma than one which appears where one did not exist before. Any solitary peripheral nodule must be viewed with suspicion but the more perfectly spheroidal ones of homogeneous density are especially suspected.

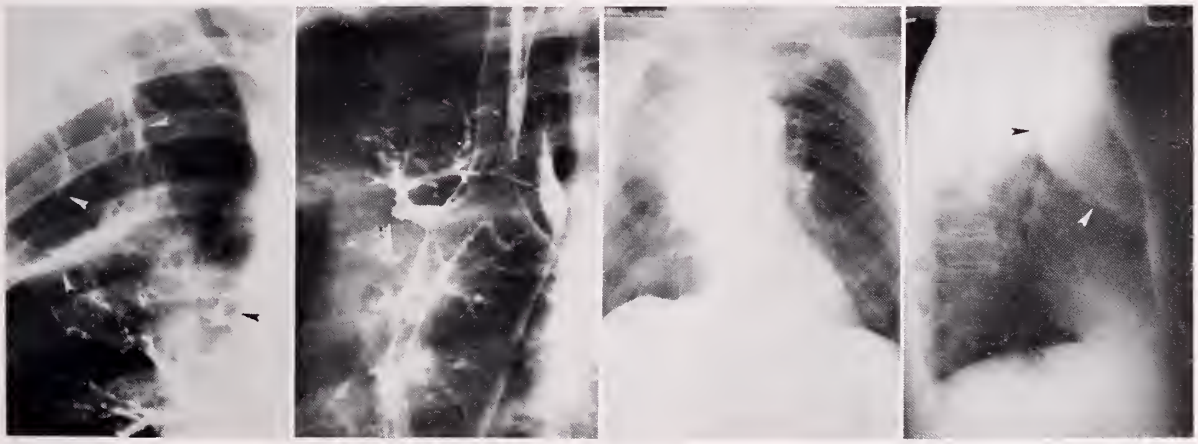
Presence of Calcium is Significant

The question of calcification in the study of pulmonary lesions is an important one. The absence of calcium does not exclude the diagnosis of granuloma as it often does not calcify, but the presence of calcium is of great significance. It is the opinion of most radiologists that the calcium present in the few reported cases of carcinoma of the lung showing calcium probably was present before the tumor growth began.

It is important to remember that laminagraphy is necessary in order to rule out the presence of calcium. Lesions which on conventional films appear of homogeneous water density often are shown to contain calcium when laminagraphy is employed. Laminagrams also may show pleural reaction not seen on conventional films. Such reaction is more common in inflammatory lesions (Figure 1-A, B, C, D).

Figure 4. Primary carcinoma differentiated from septic abscess by irregular outline and nodular cavity wall.

In 1956, a careful study of 400 cases of solitary lesion of the lung was made under the direction of the Army Surgeon General. The criteria used for solitary (coin) lesions were (1) 1 to 6 cm. in diameter, (2) rounded to ovoid with sharp, circumscribed borders and (3) surrounded by normal appearing lung on all sides. An analysis of the study revealed that 60 per cent of the lesions were granulomas, 15 per cent malignant lesions, 11 per cent chronic focal pneumonia, and 12 per cent hamartomas. A study of 52 con-



A B C D

Figure 5 (A)—Obstructive emphysema laterally. Bronchograms show partially occluded right upper lobe bronchus. (B)—Segmental atelectasis, anterior segment, right upper lobe, demonstrated by bronchography. (C)—Complete atelectasis, right upper lobe, PA. (D)—Complete atelectasis, right upper lobe, lateral view.

secutive cases in this series treated by thoracotomy indicated that a medico-surgico-radiological team approach results in increased diagnostic accuracy. It was concluded that 99 per cent of the malignancies would have been operated on while only 10 per cent of patients having a benign lesion would have been subjected to thoracotomy. It was concluded also that if the team concept is followed, the presence of calcium indicates that the lesion is benign and that thoracotomy for cancer is unnecessary.[3]

Notching or umbilication of solitary shadows best observed laminagraphically has been described by Rigler[4] as characteristic of malignancy. The cause is not entirely clear but the hilus probably is produced by blood vessels and normal lung extending into the mass. Rigler recommends that lesions showing the notch sign be removed without delay (Figure 2).

Change in size or shape of one hilus is of very great importance as a high percentage of carcinomas begin in the lung roots. They are difficult to detect in this location because of the normal irregularity of the hila. Old films for comparison are most helpful and every effort should be made to locate them. Laminagrams are of value in demonstrating the mass and in determining whether bronchostenosis is present (Figure 3-A, B, C).

Differentiation of Lesions

Infiltrating carcinomatous lesions are difficult to differentiate from those resulting from chronic inflammatory processes. Infiltrating tumor would be expected to progress more rapidly and laminagrams may show some nodularity. Demonstration of bronchial occlusion by laminagraphy and bronchography again is helpful. Often the final diagnosis is made only after extensive medical study and biopsy obtained by scalene node resection, bronchoscopy, or even thoracotomy.

Figure 6. Superior sulcus tumor. (Pancoast).

Figure 7. Right upper lobe atelectasis due to primary carcinoma occluding right upper lobe bronchus producing Golden's sign.

Acute inflammatory processes are not difficult to differentiate as they generally resolve over a period of days. Suspicion should be aroused when acute infiltration fails to resolve and when chronic inflammatory processes fail to improve. When such processes persist for a period of six weeks in an individual past 40, carcinoma must be suspected and a persistent search is indicated.

Abscess

The appearance of an abscess may be the first indication of the presence of a carcinoma. Septic abscess usually can be differentiated from malignant ones as they are more symmetrical and the air-containing space has a smooth wall. Malignant abscesses frequently are irregular peripherally and usually have nodular masses projecting into the necrotic air-containing cavity. Multiple carcinomatous abscesses occur infrequently (Figure 4).

Atelectasis or emphysema involving a small segment or an entire lung suggests the presence of a primary neoplasm which is producing some degree of bronchostenosis. The obstructive "ball valve" type emphysema is observed when the stenosis is incomplete. When the lesion causes complete stenosis or occlusion of the bronchus, atelectasis occurs as air distal to the obstruction is absorbed. Obstructive emphysema can be detected by films made in inspiration and expiration or by fluoroscopy, which is the preferred method. The emphysematous zone is evident by its constant hyperaeration and atelectasis can be confirmed by detecting displacement of intrathoracic structures, especially pulmonary fissures, pulmonary vessels, and hilar shadows.

A collapsing lobe by traction rotates the mediastinum sufficiently to conceal the ipsilateral hilus. The heart border on the affected side is more sharply defined by virtue of increased aeration within the uninvolved remainder of the lung in which there is compensatory emphysema. In the emphysematous lobe blood vessels are fanned out while they are crowded together in the atelectatic lobe. Displacement of the minor fissure separating the right upper and middle lobes can best be detected in a right lateral view. The oblique or major fissures require varying degrees of obliquity in order to observe their full extent because of their propeller shape.[5] While benign tumors and inflammatory disease can produce both obstructive emphysema and atelectasis, malignant tumors must be ruled out whenever either condition is encountered. The combination of obstructive emphysema and an enlarged hilus almost invariably connotes carcinoma. Laminagraphy and bronchography usually succeed in clearly demonstrating the stenosed bronchus or the obstructing intraluminal mass (Figure 5-A, B, C, D).

Two Specific Types

Two specific characteristic types of bronchogenic carcinoma occur with sufficient frequency to warrant description. The superior sulcus or Pancoast tumor occurs high in the apex of a lung and involves the structures passing through the superior sulcus. It often erodes adjacent ribs and involvement of the 6th and 7th cervical and 1st dorsal nerves results in Horner's syndrome. This syndrome consisting of ptosis of the upper eyelid, contraction of the pupil, anhidrosis, and arm pain of ulnar distribution on the affected side may be the first sign of carcinoma of the lung (Figure 6).

The second specific type is "Golden's S curve." This actually is a hilar lesion which has reached a large size and has produced atelectasis by occlusion of the right upper lobe bronchus. The shrinking upper lobe forms the concave upper half of the S curve while the fixed tumor mass forms the convexed lower portion (Figure 7).

Summary of Roentgen Signs

Recently appearing noncalcified solitary spherical density.

Solitary spherical noncalcified density increasing in size.

Chronic inflammatory type infiltration persisting for several weeks.

Acute pneumonic infiltration failing to resolve.

Irregular abscess with nodular walled cavity.

Enlargement of one hilus when compared with old films.

Obstructive emphysema.

Atelectasis.

Rigler hilus sign.

Superior sulcus tumor (Horner's syndrome). Golden's S curve.

Conclusions

Roentgenological examination is the only means of detecting carcinoma of the lung during the often long period before symptoms and signs appear.

After symptoms and signs develop, roentgen examination may be the only means of arriving at a diagnosis if cytology, bronchoscopy and node biopsy are not revealing.

Old films are very valuable and every effort should be made to obtain them for comparison when current films show a lesion.

A medico-surgico-radiological team approach yields far greater accuracy in diagnosis. It often avoid needless thoracotomy while assuring resection when needed.

Calcified solitary spherical lesions are not malignant and resection for cancer is not indicated.

Bronchostenosis at times manifest by obstructive emphysema but more often by atelectasis is the most valuable single indication of the presence of bronchogenic carcinoma.

All individuals over 40 should have at least an annual chest x-ray examination consisting of full size postero-anterior and lateral films.

All adult patients presenting chest symptoms and signs should have a similar examination promptly.

References

1. Garland, L. H.: Detection of Carcinoma of Lung by Screening Procedures, Am. J. Roentgenol., Rad. Therap. & Nuclear Med. 75:402-414 (Sept.) 1955.
2. Garland, L. H.: Ibid.
3. Edwards, W. M., Cox, R. S. & Garland, L. H.: The Solitary Nodule of the Lung, Amer. J. Roentgenol., Rad. Therap. & Nuclear Med. 88:1020-1042 (Dec.) 1962.
4. Rigler, L. G.: The Roentgen Signs of Carcinoma of the Lung, Am. J. Roentgenol., Rad. Therap. & Nuclear Med. 74:415-428 (Sept.) 1955.
5. Butz, G. W., Jr. & Amory, H. I.: Atelectasis: Its Diagnosis and Significance, West Virginia Medical Journal 59:183, 1963.

Outpatient Management of Hypertension

Wilbur W. Oaks, M. D., and John H. Moyer, M. D.

During the past decade numerous potent antihypertensive drugs have been introduced. In the area of drug therapy, many questions have been posed regarding the pathogenesis and mechanism of essential hypertension. Many questions have been answered, yet others remain unresolved in this field. Needless to say, intensive research must be continued if the problems in the mechanism and treatment of essential hypertension are to be solved.

Countless theories regarding the pathogenesis of essential hypertension have been voiced.[1] It is best considered as an increased vascular responsiveness to the normal occurrence or increased number of vasoconstrictor impulses. Perhaps the responsiveness is a genetic factor; thus the predisposition is then engendered by the various environmental mechanisms involved.

Approach to Treatment

A primary factor in the treatment of hypertension is that an etiologic agent must be sought by every diagnostic means available. In the interest of brevity a detailed discussion of this problem is not presented; rather, stress is placed on seeking those conditions which may produce hypertension. The disease may result from (1) hyperthyroidism, (2) coarctation of the aorta, (3) renovascular or unilateral kidney disease, (4) pheochromocytoma, (5) Cushing's syndrome, (6) primary aldosteronism and (7) diseases of the central nervous system. The exact diagnostic work-up necessary in the case of the patient with hypertension is difficult to set forth. One must have a high index of suspicion with regard to correctable lesions and the appropriate diagnostic studies indicated unless an untoward risk precludes them.

Most of the problems and complications of prolonged hypertension arise in three vascular beds, i. e., the cerebral vessels, the coronary arteries and the kidneys. It also is important to note that the benefits, problems and complications which arise from the therapy of hypertension likewise are largely related to these vascular beds.

Cerebral function in hypertensive patients is distinctly improved by lowering the blood pressure. When the blood pressure is reduced, the cerebral vessels dilate and blood flow to the brain is increased. If the blood pressure is reduced too severely, the cerebral blood flow likewise is critically reduced and changes in cerebral function such as dizziness or syncope develop. This is not an unusual occurrence when the patient on ganglionic blockade therapy assumes the upright position.

The Authors

- **Wilbur W. Oaks, M. D., and John H. Moyer, M. D., Department of Medicine, Hahnemann Medical College and Hospital, Philadelphia, Pennsylvania.**

From the cardiovascular standpoint, there is improvement in the anginal syndrome when the blood pressure is reduced. Thus an improvement in the relation of coronary blood flow to oxygen and metabolic demand is suggested. A reduction in cardiac work, brought about by a reduction in the blood pressure, compensates for any decrease in coronary flow which may occur.

Table I.

APPROXIMATE DEGREE OF BLOOD PRESSURE REDUCTION THAT CAN BE ACCOMPLISHED

Blood Urea Nitrogen (mg. %)	*Reduce Upright Blood Pressure to:*
Normal	130-150/80-100
30-60	150-170/100-110*
60-100	180-190/110-120*
> 100	No reduction

*Do not reduce blood pressure further if BUN rises.

If renal function is not significantly impaired prior to treatment, renovascular resistance decreases and renal blood flow is not altered significantly with the blood pressure reduction. If, however, impairment of renal function is present, caution must be exercised with regard to the degree and rapidity with which blood pressure reduction takes place. (Table I). It is imperative that therapy be instituted early in the course of the disorder to prevent permanent renovascular damage.

Recent concepts indicate that, if at all possible, arteriosclerotic hypertensive disease also should be given prime consideration. The relation of

hypertension to atherosclerosis still is not yet fully established, but enough evidence has been assembled to fairly well establish that hypertension rapidly accelerates the progression of atherosclerotic changes. Thus, although therapy must be directed to the individual and carried out with caution, specific treatment is indicated.

Basic Therapeutic Measures

Certain therapeutic measures have been considered basic in the management of the hypertensive patient. Although such measures have a valid therapeutic basis, when properly instituted their practical usefulness is limited because of the difficulty in adequately controlling them.

Salt restriction is a proven means of blood pressure reduction if the salt is limited to 500 mg. or less per day. There are few patients who will consistently adhere to such restriction for any prolonged period of time. With the advent of recent diuretic therapy, the salt intake may be increased, with no change in the natriuretic effect of the thiazides. As much as 9 Gm. of salt per day may be ingested without overcoming the effectiveness of thiazide natriuresis and diuresis.

Weight reduction may be of value in the obese individual with mild blood pressure elevation. The patient with severe hypertension, however, does not respond nearly so well.

Rest and sedation are well accepted as basic therapy for patients with hypertension. Sedation, tranquilizers and reassurance type psychotherapy, all can be valuable adjunctive measures in the management of hypertension. The patient must avoid wide swings from one emotional state to another if adequate control of the disorder is to be gained.

Even in the face of effective drug therapy, however, an emotional crisis will precipitate a breakthrough in the controlled state and elevation in blood pressure will ensue.

Finally, it has been shown that smoking frequently aggravates diastolic hypertension by stimulating the sympathetic ganglia. For this reason, nicotine should not be used by the hypertensive patient.

Specific Therapy

Since the advent of thiazide diuretics, dietary restriction of sodium has been liberalized with adequate therapeutic results. The ideal diet contains 3 to 4 Gm. of sodium per day; such a regimen precludes obviously salty foods and table salt.

The present outpatient management of hypertension begins with the use of one of the thiazide derivatives. These diuretic agents possess antihypertensive properties proportional to their natriuretic potency. The precise mechanism of antihypertensive action of the thiazide derivatives remains undetermined. It originally was thought that the hypotensive effect was related to a reduction in plasma volume and a consequent decrease in cardiac output.[1] Subsequently it has been demonstrated that the blood pressure reduction achieved by use of thiazide derivatives is maintained despite the administration of plasma or other volume expanders in the correction of hypovolemia.[2] It also has been noted that, in many instances, the plasma volume spontaneously returns to normal after one to two months of drug therapy.[3]

Inherent vascular responsiveness probably is related to the gradient of sodium ions existent between the intracellular and extracellular spaces. It appears, therefore, that the thiazide derivatives alter this gradient and depress the pressor response to normal stimuli. There are other pharmacodynamic considerations dealing with the antihypertensive mechanism of diuretics, but none has fully explained the definite mechanism of the hypotensive effect.

Thus, it is recommended that a thiazide derivative be utilized as the basic therapeutic agent because of (1) its individual antihypertensive attributes, (2) the relatively low incidence of accompanying side effects and (3) the drug's ability to potentiate all other available antihypertensive drugs. Studies now indicate that significant blood pressure reduction can be maintained in 40 per cent of cases, with the use of chlorothiazide, hydrochlorothiazide and flumethiazide. The dosages were 1,000 mg. daily of chlorothiazide (Diuril) or flumethiazide (Aldemal) and 100 mg. daily of hydrochlorothiazide (Esidrix, Hydrodiuril).[4]

Relatively few side effects are experienced with the administration of thiazide diuretics; where present, these untoward effects may consist of nausea, weakness, fatigue and skin rashes, e. g., maculopapular, petechiae or purpura.

Elevation of the blood urea nitrogen may occur while a patient is on thiazide drugs and hence these drugs must be administered cautiously in patients with renal impairment and elevated blood urea nitrogen. Hyperuricemia also may occur with the use of thiazide derivatives and may precipitate acute gouty arthritis. These attacks respond well to colchicine therapy but in order to prevent such attacks, probenecid (Benemia) may be used concurrently with the thiazide derivatives.

The phthalimidine compounds are potent diuretic agents which are well tolerated orally. These drugs exhibit natriuretic potency similar to that of the benzothiadiazine drugs, but have a more prolonged duration of action. Maximal antihypertensive effectiveness can be achieved with chlorthalidone (Hygroton) in dosages of 100-200 mg. per day for a period of two weeks, henceforth, the dosage may be reduced to 100-200 mg. three times per week. The natriuretic effect of chlorthalidone may persist for 48 hours or longer.[4] It is fairly well established that the kaluretic effect of chlorthalidone is greater than that of the thiazides, making potassium supplements necessary.

Finally, the newer aldosterone antagonists may prove effective in conjunction with thiazide derivatives.[5] These antagonists tend to inhibit the action of aldosterone at the distal tubular level; hence, they act at a different site from that of the thiazides and may potentiate the hypotensive effect.

If the use of diuretics alone fails to achieve the desired response after two weeks, a Rauwolfia compound shall then be added to the therapeutic regimen. By this time, the thiazide drugs have produced the maximal hypotensive response possible, and the effects derived constitute a basic regimen for further therapeutic considerations.

A large variety of Rauwolfia compounds are available, including the single pure alkaloids of Rauwolfia serpentina, e. g., reserpine, rescinnamine and deserpidine, various preparations containing multiple active alkaloids (Alseroxylon) and whole root, and synthetic reserpine-like analogues (syronsingopine).[6] Although there is statistically little difference in the antihypertensive effect obtained with these derivatives, the incidence of associated side effects is less with Rauwiloid, Raudixin and Singoserp.

The Rauwolfia compounds have both a central and a peripheral mechanism of action. These agents release serotonin from binding sites in the brain. It also has been determined that Rauwolfia drugs produce a release of catecholamines from the postganglionic sympathetic nerve fibers as well. The latter effect depletes the sympathetic fibers of their catecholamine stores and thereby decreases the peripheral response to pressor stimuli.

The Rauwolfia drugs are effective therapeutic agents because (1) blood pressure reduction occurs both in the supine and erect position (2) the mild sedative effect of these drugs is valuable as a therapeutic adjunct in the hypertensive patient and (3) the Rauwolfia drugs (as the thiazides) potentiate other antihypertensive agents.

Rauwolfia is administered for a minimum of two to three weeks before a maximal therapeutic response is achieved. It is recommended that an initial loading dose of Alseroxylon 8 mg., whole root 200 mg. and reserpine 0.5 mg. or syrosingopine 4 mg. be given during the first two weeks of treatment. Following the initial course, dosage may be reduced to half of the above values for maintenance purposes.

Various side effects occur with the use of Rauwolfia derivatives, e. g., nasal stuffiness, increased appetite, vertigo and drowsiness.[6] The most serious untoward effect is the development of agitated depression with the presenting symptom of insomnia. Side effects other than agitated depression usually can be controlled, but progression of the depressive reaction may necessitate discontinuation of the drug.

If the blood pressure remains elevated on a regimen of Rauwolfia and thiazide derivatives, then further combination therapy should be considered. With the recent advent of guanethidine, double or triple drug regimens should be instituted in order to accomplish a significant reduction in blood pressure.

Guanethidine

Guanethidine is one of the newer and most useful drugs added to the physician's armamentarium in the management of the patient with hypertension.[7] Guanethidine is a sympatholytic agent which has a hypotensive potency similar to that of the ganglion-blocking compounds. It acts by inhibition of the peripheral release of catecholamines from the postganglionic sympathetic fibers. The predominant reduction of blood pressure occurs in the upright position. This action is similar to that of the ganglionic blocking agents, but the hypotensive response occurs without the associated side effects of parasympathetic blockade. The primary side effect of guanethidine is manifested by an increase in frequency of bowel habits rather than true diarrhea. This untoward effect usually can be controlled by the use of anticholinergic drugs. Other side reactions are dizziness, orthostatic weakness and failure of ejaculation.

The most important factor in the proper use of guanethidine is the titration of dosage in the upright position. The antihypertensive effect of guanethidine usually occurs two to three days following oral administration, but blood pressure reduction is maintained for seven to fourteen days. This of course, enables the drug to be given as a single daily dose. The drug may be started

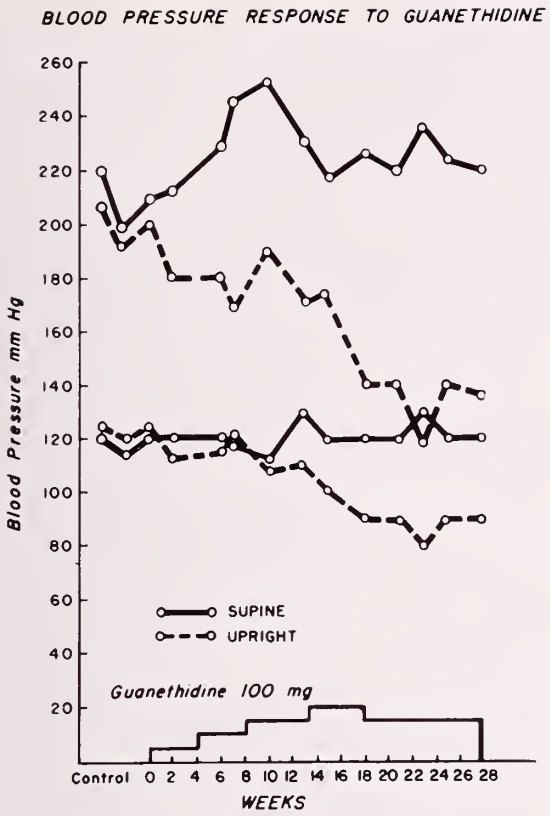


Figure 1

in the dosage range of 12.5 mg. or 25 mg. per day. It may be given as a single dose in the morning since it has a prolonged effect. The dose is then increased in increments of 12.5 mg. every five to six days until a significant response has been achieved (Figure 1). If the patient is already receiving thiazide derivatives, the dose of guanethidine is potentiated and one must cautiously increase the dose or orthostatic hypotension may occur. When guanethidine is added to the regimen, Rauwolfia drugs usually may be discontinued if they have been a part of therapy.

Apresoline

A third drug may have to be added to the thiazide-guanethidine regimen if side effects result from large doses of the latter. Apresoline has been used in the past and the triple therapy regimen was successful in most instances (Figure 2).

Apresoline produces prolonged dilatation of constricted smooth muscle and because the sympathetic impulses from the hypothalamus and vasomotor center are depressed, it has a central action.

The recommended initial dosage is 25 mg. every six hours; it must be administered at this time interval because of its duration of action. The daily dose may be doubled at weekly intervals until a satisfactory blood pressure is achieved.

The major untoward reactions observed with Apresoline include headache, palpitation and tachycardia. The cardiostimulatory effect of Apresoline produces tachycardia and hence the drug is contraindicated in patients with coronary artery disease. A mesenchymal lupus erythematosus-like syndrome may be associated with Apresoline in doses of 400 mg. (or more) per day. Apresoline should never be used as the sole antihypertensive agent.

Aldomet

With the development of the decarboxylase inhibitor, alpha methyl dopa (Aldomet), a compound which depresses catecholamine biosynthesis, Apresoline can be replaced as an adjunctive therapeutic agent.[8] Aldomet thus acts to inhibit conversion of dihydroxy-phenylalanine (dopa) to dopamine. This blockade prevents further synthesis of dopamine to norepinephrine.

Aldomet therapy is instituted at a dosage level of 250 mg. twice daily. The dose is increased at biweekly intervals to a maximum of 500 mg. four times a day. Aldomet may be utilized alone, but at present it is being utilized as an adjunctive agent with thiazides and guanethidine.

The side effects usually encountered with Aldomet include drowsiness, palpitation, orthostatic weakness, headache, fever and maculopapular rash. One of the interesting considerations in the utilization of this drug is its effectiveness in the supine position as well as the upright. For this reason, it may be effectively used in combination with guanethidine which acts almost exclusively

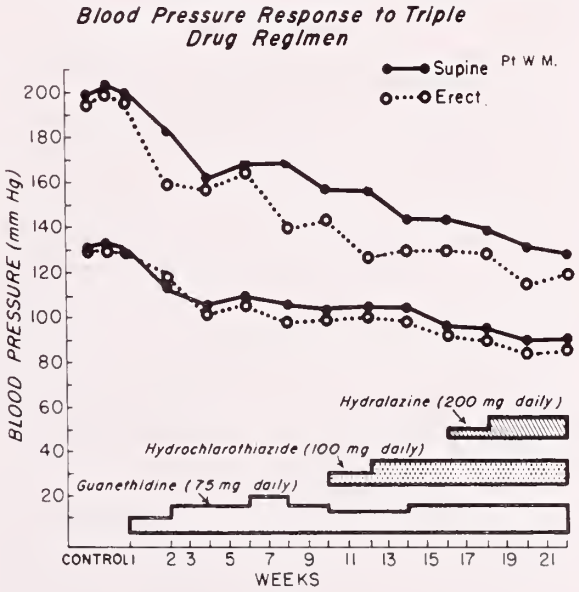


Figure 2

Table II.
COMPREHENSIVE THERAPEUTIC REGIMEN

Severity of Hypertension	*Initial Therapy*	*Adjunctive Therapy When Not Adequately Responsive to Initial Therapy*
Diastolic blood pressure > 100 mm. hg. but < 120 mm. hg.	Hydrochlorothiazide*	Rauwolfia
Diastolic blood pressure > 120 mm. hg. but < 140 mm. hg.	Hydrochlorothiazide* and Rauwolfia	Hydralazine
Diastolic blood pressure > 140 mm. hg.	Hydrochlorothiazide* and Guanethidine	Hydralazine, Aldomet or Ganglion Blocking Agent

*May use other thiazide derivatives with equally good results.

in the upright state. In subjects with advanced renal disease the dose of guanethidine may be reduced so that severe postural hypotension will not be induced.

With the availability of the drugs discussed above, it usually is not necessary to proceed to any of the more powerful antihypertensive agents such as ganglionic blocking agents or veratrum derivatives.

Ganglionic Blocking Agents

The ganglionic blockers are among the most potent antihypertensive drugs available.[9] Blockade of neurogenic transmission within the sympathetic ganglia potentiates the mechanism of action. Many such preparations include pentolinium (Ansolysen), chlorisondamine (Ecolid), and mecamylamine (Inversine). The approximate equivalent dosages are Ansolysen 20 mg., Ecolid 12.5 mg., and Inversine 2.5 mg.

Inversine probably is the ganglionic blocker of choice, primarily because its absorption from the gastrointestinal tract is complete and, therefore, the daily hypotensive response does not vary.

The larger doses of inversine are administered in the morning and at noontime, so that orthostatic hypotension will not be experienced upon arising in the morning.

The side effects experienced in the use of these agents are due to the simultaneous inhibition of neurogenic transmission within the parasympathetic ganglia. The incidence of side effects differs with each agent employed. The primary complications seen with Inversine are constipation and dryness of the mouth; with Ecolid, blurred vision and photophobia tend to be more severe. On occasion, it is helpful to switch from one blocking agent to another in an effort to control untoward side effects.

Veratrum rarely is used on an outpatient basis but, rather, is given parenterally in refractory hypertensive emergencies, particularly those associated with toxemia of pregnancy.

A summary of a comprehensive therapeutic regimen for controlling hypertension is shown in Table II.

Conclusions

There are few cases of hypertension in which the blood pressure cannot be reduced to normotensive levels with the antihypertensive agents now available.

The primary concern of the physician is to establish the cause of hypertension by means of an appropriate diagnostic work-up. Once this has been accomplished and the diagnosis of hypertension established, judicious use of the available antihypertensive drugs can begin. It is imperative that therapy be instituted prior to the development of irreversible vascular changes in the kidney, heart and brain.

References

1. Freis, E. D.: Effects of Salt and Extracellular Fluid Depletion on Vascular Responsiveness With Particular Reference to Chlorothiazide, Proc. Council High Blood Pressure Research, Vol. 7, 1958.
2. Hollander, W., Choranian, A. V. & Wilkins, R. W.: Role of Diuretics in Management of Hypertension, Ann. New York Acad. Sci. 88:975, 1960.
3. Conway, J. & Lauwers, P.: Hemodynamic and Hypotensive Effects of Long-Term Therapy With Chlorothiazide, Circulation 21:21, 1960.
4. Brest, A. N. & Moyer, J. H.: Clinical Use of Diuretics in Hypertension, Hypertension: Recent Advances, Philadelphia, Lea & Febiger, 1961, pp. 250.
5. Fuchs, M., Moyer, J. H. & Newman, B. E.: Human Clinical Pharmacology of the Newer Diuretics Benzothiadiazine and Phthalimidine, Ann. New York Acad. Sci. 88:795, 1960.
6. Ford, R. V. & Moyer, J. H.: Rauwolfia Toxicity in Treatment of Hypertension, Postgrad. Med. 23:41, 1958.
7. Brest, A. N., Kodama, R., Naso, F. & Moyer, J. H.: Guanethidine in Treatment of Hypertension, Postgrad. Med. 30:260, 1961.
8. Brest, A. N., Seller, R., Onesti, G., Sekine, G. & Moyer, J. H.: Decarboxylase Inhibitors in Treatment of Hypertension, Hypertension: Recent Advances, Philadelphia, Lea & Febiger, 1961, pp. 424.
9. Brest, A. N. & Moyer, J. H.: Management of the Ambulatory Patient With Hypertension, Am. J. Cardiol. 9:824, 1962.

Leukorrhea in the Adult Female*

Warren R. Lang, M. D., and Norman M. Woldorf, M. D.

LEUKORRHEA, increased or abnormal vaginal discharge, is not always as simple to diagnose and treat as may be supposed. All general practitioners and gynecologists eventually encounter instances in which routine measures fail. The purpose of this presentation is to discuss the principal causes and varieties, with their treatment, the methods of diagnosis, peculiarities in pregnancy, and the resistant and recurrent cases of leukorrhea in the adult female.

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Causes of Leukorrhea

There are many etiologies for leukorrhea in the adult female. In general, they may be classified into two groups: physiologic and pathologic.

So-called "physiologic" leukorrhea refers to those cases in which there is no infection, but there is increased vaginal discharge due to an accentuation of normal processes. This may occur (1) at puberty when the increasing blood estrogen level stimulates both the vaginal epithelium and the cervical glands, (2) occasionally during the premenstrual period when there is apparently a transudation of fluid through the vaginal wall, (3) during pregnancy from the hyperhormonal state (although most leukorrhea in pregnancy has an infectious origin), (4) in the postnatal period from the withdrawal of hormonal support and the sloughing of the endometrium and (5) rarely, with the onset of anovulatory cycles in the early menopausal era when the estrogen is unopposed by progesterone. Physiologic leukorrhea usually requires no treatment except reassurance; sometimes, except in the puerperium, a mild douche or other local treatment may be utilized.

Pathologic leukorrhea may have many etiologies. Predisposing factors are poor hygiene, low socio-economic status, foreign body, trauma, elevated vaginal pH, thinned vaginal epithelium, contact with other individuals harboring an infectious agent, pregnancy, systemic disease such as diabetes mellitus which may predispose to candidiasis, and the use of drugs such as broad spectrum antibiotics which also may encourage the growth of *Candida sp.* Latent subclinical infections may flare up when a more flagrant infection is controlled. There are, of course, many other factors poorly understood and unrecognized.

In the following pages each major variety of vaginitis will be discussed. Included under each entity will be the symptoms, pelvic findings, laboratory procedures necessary for a specific diagnosis, and the treatments of choice. In turn, this will be followed by a discussion of the all-important wet smear as well as a chart which summarizes the major findings of history, pelvic examination and laboratory procedures in each case.

The four major types of leukorrhea arise from infection with *Trichomonas vaginalis*, infection with Candida sp., bacterial infections (such as E. coli or beta hemolytic streptococci), or from an atrophic vaginal epithelium with or without a superimposed infection.

Trichomonas Vaginalis Vaginitis

Trichomonas vaginalis, a protozoan flagellate, produces a diffuse inflammation of the vulvovaginal mucosa. Although the infection can occur at any age, it seems to favor women in the childbearing era. It may be transmitted by the husband or consort, or may follow a severe illness or pelvic operative procedure. It is especially frequent in pregnancy, most commonly in women of lower socio-economic status.

Profuse leukorrhea is usual. The discharge is malodorous, purulent in character, yellow-green and bubbly. The vulva also may be inflamed, with pruritus present. Dyspareunia may occur. The vagina and cervix are inflamed with a stippled ("measles"), or roughened ("strawberry") appearance.

Diagnosis is made by history, pelvic examination and, most effectively, by wet smear in which motile organisms slightly larger than a white cell

*Presented by Doctor Lang before the Eighth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 25-27, 1963.

Submitted to the Publication Committee, May 20, 1964.

are seen in normal saline solution. Cultures (e.g., Simplified Trypticase Serum) are available. The organism also may be noted in Gram-stained or Papanicolaou-stained smears. In the presence of trichomonads, cytologic squamous cell atypia of a minor nature is commonly found. If the class is III or above, biopsy is indicated, especially if the atypia does not regress with therapy for the trichomoniasis.

The multiplicity of therapeutic agents and methods advocated in the past for therapy attest to the fact that no single agent was actually very effective. With the advent of metronidazole*, a great advance in treatment has been attained. Whether the drug, which is administered orally, need be accompanied by vaginal metronidazole, whether the husband need be treated and whether it is completely safe in all stages of pregnancy are yet to be determined. The oral dosage is 250 mg. three times daily for ten days. Vaginal metronidazole, 500 mg. tablets, once daily for the same ten days also may be used as additive therapy. The oral dose for the husband is the same as for the wife and should be given concomitantly. The most frequent side effects are indigestion, a metallic taste and, sometimes, a furry tongue. Repeat courses may be required.

The more traditional therapies consist of such local medicaments as arsenicals (Carbarsone suppositories, Lilly; acetarsone with hydrolyzed carbohydrates, Devegan tablets, Winthrop); silver picrate (picragol suppositories, Wyeth); diodoquin compounds (Vioform inserts, Ciba; Floraquin tablets, Searle); oxytetracycline (Terramycin-Polymyxin B viginal tablets, Pfizer); and many others. These medications must be utilized once or twice daily for many weeks and often repeated. Douching as a cleansing and flushing measure may precede each insertion of the drug employed if desired.

Vulvovaginal trichomoniasis tends to recurrence and resistance. It is well to check the husband, as well as the cervix, Bartholin's glands, urethra and bladder of the patient when a "cure" is not easily forthcoming. Treatment can be unusually frustrating.

Vulvovaginal Mycoses

The commonest fungus (actually a yeast-like fungus) inhabiting the vagina and vulva and producing symptoms is *Candida albicans*. This fungus often is found on normal skin and is easily carried to the anogenital area. Transmission from the husband, especially if he is uncircumcised, is probable; the organism may be acquired also from various fomites. The major predisposing causes of infection are diabetes mellitus, pregnancy and the use of broad spectrum antibiotics. The infection also may flare up following succesful therapy for trichomoniasis (because the fungus probably was unrecognized previously) and, rarely, subsequent to cortisone therapy. Estrogen cream for atrophic vaginitis also may encourage its growth.

The major symptom is pruritus; this is vaginal or vulvar in origin, or both. The accompanying discharge usually is scanty, resembling amniotic fluid grossly, and is highly irritating. A "musty"

*Flagyl (Searle)

Table I

SUMMARY OF DIAGNOSIS OF MAJOR VAGINITIDES

	Trichomonas Vaginalis Vaginitis	*Candidal Vulvovaginitis*	*"Nonspecific" Vaginitis*	*Atrophic Vaginitis*
PREDOMINANT SYMPTOMS	Purulent, profuse, yellow-green, bubbly leukorrhea. Pruritus Dyspareunia	Pruritus Scanty discharge Dyspareunia	Discharge, varying in nature.	Thin, serous discharge, occasionally bloody.
PELVIC FINDINGS	Discharge Vaginitis Vulvitis "Strawberry" or "measles" vaginitis	"Cottage Cheese" appearance. Vaginitis Vulvitis Vulvar edema	Inflamed vagina	Thin, inflamed vaginal epithelium.
SIGNIFICANT LABORATORY FINDINGS	Wet smear shows motile trichomonads, inflammatory cells.	Hyphae by wet smear.	Wet smear shows many inflammatory cells. May see bacteria.	Wet smear shows many atrophic (parabasal) and white cells, per haps red cells.
	Positive culture for trichomonads.	Positive culture for fungi.	Many bacteria by Gram-stain. Bacterial cultures may show specific micro-organisms.	Occasionally must check for trichomonads, *Candida sp* and bacteria.
	Papanicolaou smear shows trichomonads, perhaps atypism.	Papanicolaou smear shows hyphae. Check for diabetes mellitus.	Papanicolaou smear indicates inflammation.	Papanicolaou smear shows atrophic changes.

odor is present. The vulva, vagina and cervix are reddened, with the latter two areas demonstrating white patches ("cream cheese" or "cottage cheese" vaginitis). The vulva, which is tender, may be edematous in severe cases. Evidence of scratching may be apparent.

One of the oldest but, nevertheless, effective means of management is local application of gentian violet (methyl rosaniline chloride). Many preparations are available: Gentia-Jel, Westwood; Gentersal, Ortho; Gentian Violet Suprettes, Webster; and others. Gentian violet preparations have two drawbacks: "messiness" and occasional sensitization. Fatty acids also have been used, especially propionic acid. Iodine is an old mode of therapy; it recently has been tried in a modified form as povidone-iodine, Betadine Vaginal Gel, Tailby-Nason. A fairly new chlordantoin preparation has been used, Sporostacin, Ortho. One of the most popular drugs is nystatin, Mycostatin, Squibb. All these and other preparations should be given for at least several weeks; each application may or may not be preceded by a cleansing douch. We have found baking soda douches, 4 tablespoonfuls to 2 quarts of water, quite soothing.

Since vulvar pruritus as well as vulvar edema and soreness are common in vulvovaginal candidiasis, soothing medicaments applied to the vulvar area are often helpful. Whatever is used should be mild. Cool witch hazel compresses are comforting. Pads already impregnated with witch hazel (Tucks, Fuller) are available commercially. Cool, concentrated baking soda compresses or various cortisone preparations are of value.

Nonspecific or Bacterial Vaginitis

By definition, "nonspecific" vaginitis refers to vaginitis not produced by trichomonads, fungi or gonococci. In our experience it is the least common of the vaginitides we are discussing. Even though clinically the cervix and vagina are inflamed and the wet smear shows many leukocytes, the micro-organisms cultured may be those present in the vaginas of patients without vaginitis. It is of course quite possible that a virus may be the etiologic agent. When specific bacteria are thought to be causative, the usual ones found are streptococci, colon bacilli and staphylococci. Sometimes unusual bacteria such as *Clostridia sp.* or hospital acquired staphylococci are cultured. Gardner and Dukes have described a clinical entity from *Hemophilus vaginalis.* Moreover, nonspecific vaginitis may result from a foreign body or may be caused by various chemicals used in douches or other medications. In many instances the true origin of this type of vaginitis remains unknown.

The leukorrhea in nonspecific vaginitis varies in amount and character. The vagina and cervix show signs of inflammation. The vulva usually is unaffected but may be reddened, especially in obese women during hot weather. Pruritus is infrequent. Wet smear shows many white and parabasal cells. With *Hemophilus vaginalis* vaginitis "clue cells" are seen; these are large vaginal epithelial cells with granular cytoplasm and indefinite cell membrane, and with a multitude of the specific organisms covering its surface. Bacterial cultures with sensitivity testing are required in all resistant cases of nonspecific vaginitis.

Quite naturally, the treatment of this type of vaginitis varies with its cause. Mild cases are easily managed with lactic acid douches (USP lactic acid, 1 teaspoonful to 2 quarts of warm water). Various sulfa preparations may be used as may penicillin or Terramycin-Polymyxin B vaginal tablets (Pfizer). If, in a particular case, specific organisms in more or less pure culture are discovered, these should be eradicated by specific medications determined by sensitivity testing.

Atrophic Vaginitis

Atrophic vaginitis, sometimes called senile vaginitis, is an inflammation of the estrogen deficient, thin vaginal epithelium. Needless to say, an atrophic vagina is normal as the woman's life extends beyond the menopause. The woman is said to have vaginitis only when symptoms or signs are evident. Atrophic vaginitis is not necessarily a postmenopausal phenomenon. Decreased ovarian function from surgical or radiologic castration, primary organic ovarian disease, ovarian deficiency secondary to decreased pituitary function, increased androgen production, or exogenous androgen also may be related.

Symptomatically, atrophic vaginitis is characterized by a thin, watery discharge. If a superimposed trichomonal or candidal infection exists, the symptoms and findings are those described previously. In atrophic vaginitis the epithelium appears thin and less succulent; areas of petechiae, however, are present. Consequently, the epithelium bleeds easily. Small fissures and ulcers may develop and, with healing, vaginal adhesions may form.

Most cases of atrophic vaginitis respond to cleansing and acidifying douches such as lactic acid. A buffered vaginal jelly, Aci-Jel, Ortho, also is available. Local estrogenic creams, e. g., Premarin Vaginal Cream, Ayerst, or Dienestrol

Cream, Ortho, are specific. Systemic estrogen is very rarely indicated merely for atrophic vaginitis.

Diagnosis of Leukorrhea

The diagnosis of leukorrhea rests on three lines of investigation: history, pelvic examination and special tests.

The wet smear is the most important step in making a definitive diagnosis. It must be performed on every woman who complains of vaginal discharge. The technique is simple. Secretions are collected on a cotton-tipped applicator from the posterior vaginal fornix. The swab is then placed in two cubic milliliters of normal saline; a drop or two of this is then examined microscopically. There are eight elements that may be seen. These consist of normal and abnormal elements. The normal elements are: (1) squamous cells: mature or deeper layer (parabasal cells), (2) white blood cells, (3) bacteria, (4) spermatozoa and (5) debris. Abnormal elements are: (1) trichomonads, (2) hyphae of *Candida sp.* and (3) red blood cells (normal during menses, and a few also may be seen at the time of ovulation).

Other tests include gram-stained smears to indicate which bacteria are present, cultures for trichomonads, fungi, and bacteria, Papanicolaou smears, biopsies of suspicious lesions, fasting blood sugar (especially in nonpregnant women with candidiasis and, occasionally, the Frei test and VDRL. Methods of diagnosis are outlined in Table 1.

Vaginitis in Pregnancy

Leukorrhea occurring in the pregnant patient may be exceptionally troublesome. Infrequently it is physiologic and in such instances, the discharge appears clinically normal. Wet smear shows only mature squamous epithelial cells while the Papanicolaou smear may demonstrate cytolytic changes, i. e., lysis of the cytoplasm. Such leukorrhea needs no therapy other than an explanation to the patient or some mild tablet or suppository.

Most often, leukorrhea in pregnancy is attributable to trichomonads or candida, a combination of these two infections being not uncommon in women of the lower classes. Local vaginal measures are preferable in pregnancy. In combined infections either the predominant one is treated exclusively or alternate days of therapy for each infection may be instituted. The physician must be especially alert to a change in etiology of the vaginitis during therapy.

Resistant-Recurrent Vaginitis

On occasion, the physician encounters resistant, recurrent cases. At this time it is well to remember the following eight basic principles responsible for unsuccessful treatment: inadequate review of previous medications, inaccurate diagnosis, inadequate or incorrect medication, true reinfection, change in diagnosis, insufficient duration of therapy, overtreatment, and vulvovaginal sensitivity to the drug.

Once the problem is solved, there are many modalities of therapy. Local agents for therapy of vaginitis may be divided into douches, insufflations, tablets, suppositories, creams and jellies. Aerosols, medicated tampons, painting or scrubbing the area with different medicaments have also been recommended. Although douching, preferably preformed while lying down, is only a temporary cleansing measure, it seems to produce a brief respite from symptoms. The douche bag should be of two-quart capacity and should be approximately two feet above the vagina. Intravaginal creams and jellies applied with an introducer are desirable in that they coat the vaginal canal; suppositories, however, seem to work equally well. Abnormalities of contiguous areas such as the urethra, vulvar skin, and perianal area should be corrected.

Other than metronidazole for trichomoniasis, systemic measures are not too effective. Antibiotics by mouth or by parenteral administration are of only occasional value for adult vaginitis. General and local hygienic measures should always accompany any therapeutic regimen for leukorrhea.

Summary

The symptom of leukorrhea is truly part of "minor gynecology," but it may still pose a major problem for the patient and physician. The principles in treating leukorrhea are to determine the cause or causes, to treat with agents as specific as possible, and to check periodically to be sure the diagnosis is correct and has not changed during therapy. In order to avoid complications and to effect successful management, thorough investigation must precede treatment.

References

1. Gardner, H. L. & Dukes, C. D.: Hemophilus vaginalis Vaginitis, Am. J. Obst. & Gynec. 69:962, 1955.
2. Lang, W. R.: Experiences in a Vaginitis Clinic. JAMA 174:1814, 1960.
3. Lang, W. R., Israel, S. L. & Fritz, M. A.: Staphylococcal Vulvovaginitis. Report of Two Cases Following Antibiotic Therapy, Obst. & Gynec. 11:352. 1958.
4. Teton, J. B. & Treadwell, N. C.: Evaluation of a Systemic Trichomonacide, Obst. & Gynec. 21:356. 1963.
5. Zacharias, L. F., Salzer, R. B., Gunn, J. C. & Dirksheide, E. B.: Trichomoniasis and Metronidazole, A. J. Obst. & Gynec. 86:748, 1963.

Special Article

Strengthening Blue Shield®*

Russell B. Carson, M. D.

As with most federated organizations, Blue Shield® has grown from a loosely knit association of nine independently-developed, medically-sponsored prepayment Plans into a well structured organization of 75 Plans—each responsible to one another for the maintenance and protection of a common symbol.

This symbol, Blue Shield, represents to some 50 million people in the United States an idea and a personal service which has earned their confidence in its stabiltiy and strength. Indeed, if underwriting arrangements were such as to permit individual employees within employed groups throughout the country to select the prepayment plan of their own choice, there is no question that many more millions of the citizens of this country would belong to Blue Shield.

This fact is attested to by the overwhelming choice of the federal employees for Blue Cross and Blue Shield as against both our commercial competitors and the various independent plans that have qualified for enrollment of federal employees.

The Blue Shield symbol has come to cast an image—in some cases a very clear and discernible one—and in other instances the image is hazy, but nevertheless a favorable one.

In the independent growth of the 75 Plans which have associated themselves under the symbol of Blue Shield, strength has been gained by the autonomy and independence of each of these Plans. There has been, to some degree, a locally sponsored competitiveness which is inherent in any home-grown product. The independence of various Plans has permitted experimentation, growth, the creation of variations to meet local needs, or to suit medical facilities and local medical temperaments. The flexibility of these Plans has enabled them to adapt themselves to dissimilar geographical areas and to the wishes of various ethnic groups and economic strata.

Nevertheless, just as the 13 colonies found it advantageous to unite under one recognizable flag and to build a strong democratic union, so the strength of each Blue Shield Plan can be and has been vastly enhanced by the building of the strong image which we recognize as Blue Shield.

In defining the image of Blue Shield and in making it come alive, certain common precepts and certain common factors have come together to produce a constant and recognizable product. For this purpose, in 1950, the National Association of Blue Shield Plans established membership standards, and the Conference of Plans—the ultimate governing Body of our Association—made it a basic requirement that any medically sponsored Plan desiring to use the Blue Shield symbol would thereafter have to meet and live up to the membership standards of the Association. In fact, each Member Plan is required to certify annually that it has met and maintained these membership standards.

Our membership standards permit broad latitude to the Plans so that they maintain a high degree of individuality and independence. This has contributed to the strength of Blue Shield. At the same time, it has been a source of weakness to Blue Shield when we have been challenged to present uniform programs to employers or employed groups which have been increasingly demanding uniform benefits on a nationwide basis.

Too much diversity among the various Plans within a single state or region has sometimes deprived Blue Shield of the strength and authority and responsiveness to market requirements which Blue Shield must have if it is to meet the challenges of our present day society.

The Author

• **Russell B. Carson, M. D., Ft. Lauderdale, Florida, Chairman of the Board, National Association of Blue Shield Plans.**

***Presented before the Council of the West Virginia State Medical Association during the 97th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1964.**

A Common Goal

In West Virginia, because of its geography and the isolation of its medical units, there was at one time an extreme proliferation of local medically sponsored Blue Shield Plans. Fortunately for all concerned, the total number of such Plans has been reduced over the years from nine to six. We should keep in mind that all six of these Plans have a common goal, all have a similar product and all share the burden of problems and challenges which, if not met in concert, could lead to disaster for all of us.

One recalls Benjamin Franklin's famous remark that "If we do not all hang together we shall most assuredly hang separately."

Now it would seem that with the passage of time there has come to be less and less distance between the West Virginia Plans; the mountains are not so high; the telephone communications are more immediate and more direct; and the highway distances have been cut in half. Therefore, the reasons for independent existence have been largely neutralized.

It is not part of the function of the National Association of Blue Shield Plans to interfere with or attempt to control local Plan activities. Only when a Plan is confronted with administrative, financial or sponsorship difficulties on which the advice and assistance of our National Office can be helpful—and then by invitation—do we play some part in local affairs.

It is clearly our duty, however, to bring to the attention of Plans problems which exist in Plan areas and which affect the welfare and security of Blue Shield as a national movement. It is no less our duty to help local Plans in seeking solution to these problems through common effort and cooperation.

The Need for National Contracts

During the past several years, in fact almost since the inception of the organization known as the National Association of Blue Shield Plans, we have been trying to develop a product which can be recognized in the market place as a National Contract for Blue Shield. The need for some such recognizable contract, available nationwide, is becoming more urgent every day. As our industries are growing larger and larger and are crossing state boundaries, as our employed force is unionized in larger and larger units throughout the country, and as both management and labor are seeking to bargain ever more frequently on a nationwide basis, so the necessity for a single recognizable benefit program has become more and more a pressing problem for Blue Shield.

Last year, the Executive Committee of our National Association took this problem as its first order of business and made itself the Enrollment Committee of National Blue Shield. It spent uncounted hours in an effort to find a solution to the problem. Nearly everyone recognizes that if we do not solve the problem of providing a national Blue Shield contract in the very near future, the national accounts which now constitute a major portion of Blue Shield business in many areas may soon be lost to us.

A proposed national contract in outline was presented to the Conference of Plans at its Miami meeting in April 1964. It was accepted by the Conference and therefore became an instrument of Blue Shield.

Blue Shield in West Virginia

Scarcely less urgent than the need for a national contract is the importance of coordinating the affairs of our individual Plans in order that they may act as one force and speak with one voice in meeting national needs and solving national problems. With this thought in mind, I would like to address myself frankly to your Blue Shield situation here in West Virginia.

Speaking to you as a fellow practicing physician, I would call your attention to the importance of our profession being able to exert its rightful and necessary influence in shaping and controlling the destiny of Blue Shield.

Blue Shield is a creation of the medical profession, intended basically to help our profession meet its public responsibility.

Blue Shield serves the people best when it serves the medical profession best. Hence, it seems to me that you, my colleagues in the West Virginia State Medical Association, could far more effectively serve your own patients if you could bring about a closer collaboration—ideally a complete union—of the six independently operating Blue Shield Plans in West Virginia.

As some of you know, I have been aware of your problem for quite a long time. I had the privilege of addressing the House of Delegates of your Society in 1958 and at that time the subject of our deliberation was the same as it is today. We in the National Association feel that there would be many potential benefits if you could bring about a union of your six Blue Shield Plans.

Certainly, it would strengthen your position and ours in relation to national accounts.

It would make Blue Shield throughout your state more responsive to the needs and aspirations of our profession.

It would greatly contribute to a more efficient and economical service, both for the people and for our colleagues in medical practice. It seems to us that a single Blue Shield Plan serving all of West Virginia would permit the profession and the Plan to have a single policy, a single voice and a stronger Blue Shield.

We physicians in this country need as urgently today, as we have ever needed a strong Blue Shield; for Blue Shield is our greatest strength against the inroads of government into our private practice.

Blue Shield-Medical Society Relationship

Occasionally, Blue Shield is criticized for a lack of responsiveness to the wishes of the physicians in some areas. But, when one looks into it, it is almost always found that there has been a lack of communication between the two organizations. The profession has permitted its essential controls to slip away as the sponsoring medical organization.

A good Blue Shield-medical society relationship means that the policies and programs of the Plan will always be in accord with the wishes of the majority of physicians who participate in that Plan. There will always be some who do not participate actively and who do level criticism. These are usually the same people who fuss about the man in the White House and never go to the polls to vote.

If you want a voice in Blue Shield, be a part of it. We consider that the voice of the House of Delegates of any state association should be the voice that determines the medical policy for Blue Shield within that state. Otherwise, the symbol of Blue Shield as a service organization, sponsored and controlled by the medical profession, is a meaningless emblem.

Service Benefits

I would like to conclude with one more main thought. Your West Virginia Plans have always adhered to the principle of *service benefits* and for this you deserve great credit.

A good service program, adequate to meet the needs of the majority of the people by guaranteeing full payment of their medical bill through the premiums they have prepaid for this service, is our strongest and perhaps our only assurance of the future of Blue Shield.

A good service benefit program is the one unique difference between Blue Shield and the insurance organizations which are competing with us.

Only you—only the organization of physicians—can create and produce a service program. Never let this vital instrument pass from your hands. It takes constant safeguarding and constant vigilance for us to stay out of the trap which is set for us on all sides by our competitors.

We will not meet our competition and beat it by copying the methods, the gimmicks, and the propaganda of the commercial insurance industry, which, at times, seems to offer us such a logical and easy way to solve our problems. We will solve this problem in a manner that will do credit to medicine and meet the real needs of our patients only if we preserve the priceless asset we have built for ourselves in the *service benefit concept.*

Keep in mind that every one of our competitors would give his eye teeth to be able to offer a service plan tomorrow, if he had the means of obtaining it. It is because they recognize its great value that our competitors have been so active in developing a myriad of substitutes for service.

If we lose our right to provide service for our patients and if we lose the right to control the medical policies of Blue Shield and to provide its service program to the public—on that day we will have lost the control of the economies of medical practice. And I don't believe we would ever get it back.

Unity—cooperation—a devotion to the public welfare—hard work—and service—these are the elements of success and security for the future of voluntary medicine in America.

Special Article

Cancer Control and the Private Physician

N. H. Dyer, M. D., M. P. H.

For more than two decades, the practicing physicians of West Virginia have engaged in a working partnership with the State Department of Health, successfully forwarding the aims of a cancer control program. Despite limitations imposed by meager financial resources, which periodically result in drastic cutbacks in services, the program has nonetheless provided an outstanding demonstration of how government can serve the needs of a special population group, efficiently and with minimum demands for funding.

In retrospect, two characteristics mark the progress of 20 years: education, early case finding, diagnosis and treatment have been extended to significant numbers of medically indigent patients who otherwise would have contributed increasingly to the growing mortality from cancer; and the effort has been remarkably free from the loss of rapport, carpings and recriminations that so often emerge from other governmental adventures in medical care.

In fact, it was only through active support of the West Virginia State Medical Association and efforts of individual physicians that sufficient momentum was achieved to move a bill through the 1943 Legislature, creating the Division of Cancer Control in the State Health Department. About one year elapsed before organization was completed and all available services extended to recipients.

Optimum Utilization of Resources

Since its inception, however, the program has moved successfully within the framework of traditional physician-patient relationships and one of its more obvious strengths is related to the involvement of practicing physicians in planning for an optimum utilization of resources. Now, as from the beginning, the Cancer Committee of the State Medical Association serves as an advisory group to the Division of Cancer Control, assisting in the refinement of administrative techniques for delivering services and approving necessary changes in policy.

In terms of benefits to a population group, composed of individuals least likely to have the means or knowledge to take advantage of preventive medical services, the impact of this involvement becomes apparent from a brief examination of state funding for cancer control. The first appropriation was $50,000, at which time the all-inclusive daily hospital cost was $4.50. Subsequently, the appropriation was increased to $75,000, but hospital rates increased disproportionately to $8 and $12. By the time appropriations reached $90,000 and $100,000, hospital charges were up to $18 and $20 a day. Last year, when a further increase of $25,000 was approved by the Legislature, the ceiling of $20 a day for reimbursement of hospitals was lifted and all rates increased. Furthermore, since larger hospitals can better serve the needs of cancer patients, these institutions are utilized more frequently. But it is the larger hospitals, of course, which are most subject to increasing costs, reflected in higher rates.

Significantly, the problem has only been resolved, to some extent, by a reluctance on the part of physicians to seek or accept an adjustment in fee schedules for more than 20 years. Thus, private practitioners in this state still cooperate wholeheartedly in cancer prevention for medically indigent patients, continuing to accept a near-token reimbursement for professional services. Their willingness to continue the arrangement has been in deference to the financial needs of hospitals, the lack of a hedge available to these institutions against rising costs from demands for more comprehensive services and facilities—and knowledge that unless hospitals receive something approaching realistic payments their only recourse is to pass along the difference to other patients.

But, more importantly, physicians have recognized that efforts to obtain adequate funding for the program progress far slower than the growing problem of cancer control—and until the situation is rectified, resources will continue at a level far beneath needs of patients. Consequently, by foregoing reasonable expectations on their own part, physicians have contributed materially to an effort to extend cancer control services to as many patients as possible.

The Author.

- **N. H. Dyer, M. D., M. P. H., State Director of Health, Capitol Building, Charleston, W. Va.**

Drastic Changes in Magnitude of Problem

Actually, the ratio of expenditures under the program varies little from year to year. From the state appropriation, approximately two-thirds is spent for hospitalization, one-third for surgery and radiation. But we have witnessed drastic changes in the magnitude of the cancer problem, leaving no alternative but stricter adherence to aims of the program: increased efforts in early case finding and better utilization of funds for management of the early case with a favorable prognosis. Such misunderstandings which may arise are usually related to the physicians's compassion for his patient.

For the most part, however, there is widespread acceptance that limited funds cannot be used for terminal cases. And through other agencies we have often been able to arrange care for advanced patients. Nevertheless, in a program where funds are so limited that services are frequently terminated as we approach the end of fiscal periods, how closely must we draw the line? How many lives could be saved by an all-out effort at education and case finding among the population at risk? Could the ratio be increased by more liberal criteria for eligibility?

Even by assigning full weight to bias elements introduced by reporting, vital data substantiate concerns over the growing need for decisive moves in effective cancer control. For example, in 1920 only 280 deaths were reported from the disease, or three per cent of the total of 9,334. This was one year before reporting of births and deaths became compulsory in West Virginia, five years before the state qualified for membership in the National Birth and Death Registration Area. By 1940, the per cent of total deaths had increased to 8.3, or 1,459 in 17,577 deaths. In 1960, the figure was 14.3 per cent, or 2,580 in 18,040 deaths. Although 2,674 deaths from cancer were listed in the total of 19,405 during 1963, the percentage dropped slightly to 13.8. This decrease of a half of one per cent certainly is not viewed as progress against the disease but more as an anticipated variable. And, parenthetically, we might note that the gain was more than offset by an increase of 1.1 per cent in deaths from heart disease.

Assessment of Credits and Debits

Certainly, it is recognized that increased mortality from cancer, as in other chronic diseases, is attributable mainly to gains in longevity. But if further progress is indicated, how can we reconcile data which indicate only half of 3,703 new cases reported to the Central Cancer Registry in 1963 were diagnosed while the disease was localized?

Thus we are led to an assessment of debits and credits in the program:

Early case finding is still grossly inadequate, but steady gains have been noted since 1957 when first information became available from the Central Registry.

Education is the first point of our cancer law and voluminous material is supplied the public through organized groups, but many of the indigent and medically indigent are not being reached.

Mortality from cancer of the uterus has dropped 50 per cent in a generation, the Pap test is well on its way to establishing a new health habit among women, but a significant proportion of the other 50 per cent could be saved by an all-out effort.

It is now possible to measure survival time of cancer patients and elicit invaluable data for the profession from our Cancer Registry, but so far we have been unable to obtain funds for personnel to get the job done.

We are now prepared to move ahead in the area of smoking and cancer, but cannot do so until sufficient funds are available to do what must be done for cases at hand, with additional amounts of education.

Picture Highly Encouraging

Since its inception, the cancer control program has processed more than 18,000 cases. Today there are still approximately 6,200 persons who receive periodic observation and follow-up. Obviously, with a time lapse of 20 years, no valid index of survival can be inferred from such comparisons. But the picture is highly encouraging and, when we can adequately evaluate results of cancer control, even to the limited extent of the effort in this state, there can be little doubt of the impact on the public and appropriating bodies—and we can only speculate as to resources that may be made available to mount an adequate attack on the problem.

At present, the Division of Cancer Control receives more than 100 new applications for aid each month. Increased public education, coupled with a depressed economy and larger numbers among the indigent, has resulted in demands that continually exceed resources.

It is noteworthy that of the thousands of patients seen in tumor clinics, no physician in this state has ever accepted payment for his services to them in these settings. Nor would there have been a cancer control program here without the efforts of private physicians. Nor would it have survived without their active support and social consciousness.

For the most part, the future of the program will continue to depend on their perceptions of needs, their cooperation and their support of efforts to extend its services.

The President's Page

1965

As we turn the page to the beginning of a new year, we stand confronted with many old and some new problems in the critical months ahead. "History has not been written, nor great issues decided, by those who temporize or draw back in the face of a storm."

With our State Legislature and the new Congress meeting within a few days, we must be prepared to show reasonable men that our position is honest, just and right. We are resolved to explore all avenues of communication, but to remain firm and resolute when we know that medicine is right.

Of greatest concern remains the congressional viewpoint on Health Care for the Aged. That we as physicians have always been *for* complete medical care for *all* our citizens, regardless of ability to pay, seems to have been forgotten or purposely overlooked. That the Kerr-Mills law actually covers the needs of the older citizen best, if the Federal administration would enthusiastically endorse and promote its usage, is well known to those of us in medicine but the social planners are not really interested in its greater usage, nor its benefits to the elderly, being interested primarily in socializing the Medical Profession.

This new year with its many problems, its ever increasing financial drain on our State Association's finances, plus the many attempts to divide us, will be a most critical one. Might I ask that you actively support and participate in your local county medical society, your State Medical Association and our parent organization, the American Medical Association, to the utmost of your ability. Today as never before, you, the individual practitioner, are the backbone of medicine. Together, we find ourselves on the firing line. May I call for your active support and aid in solving the problems in this new year.

A questionnaire has been placed in the News Section of this issue of Your *Journal*. It is of vital importance that each of you take the time Today to complete and mail this questionnaire. Results of this survey will play a big role in the future of Your *Journal*.

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

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EDITORIALS

WHITHER WEST VIRGINIA BLUE SHIELD

Blue Shield voluntary medical-surgical insurance plans, sponsored or approved by county or state medical associations, have grown from a meager beginning in the 30's to 76 in number, with a reported enrollment of 52,102,664 at the end of 1963. This number represents 27 per cent of the United States population. Most of the increase in the number of subscribers has taken place since 1945, when only 2,845,000 persons were so protected. Although the numerical increase in enrollment and the marked upgrading of subscriber benefits over the years has been a notable achievement, there has been definite evidence in the past few years that we are arriving at an enrollment plateau.

(Elsewhere in *The Journal* (Page 15) there appears an article, "Strengthening Blue Shield," by Dr. Russell B. Carson, Chairman of the Board of the National Association of Blue Shield Plans).

Commercial insurance companies, at first hesitant to enter the uncharted field of health insurance, have since provided fierce competition with more than 900 commercial companies now selling an infinite variety of policies. Blue Shield has lost many of its preferred groups to this competition. It has been necessary over the years for Blue Shield to change certain early concepts such as community rating, upgrading and broadening the scope of services provided in basic contracts, making available different certificate benefit levels, as well as adding riders to insure against specific risks. This has been the result of an insistent public demand for increased protection.

Much of the success of commercial insurers has stemmed from the fact that they are able to offer attractive packages including life insurance, sick pay and other benefits in addition to the traditional hospital and physician coverage. These flexible programs have had great appeal to labor. Today, 75 per cent of our population is insured against the cost of illness to some degree. Of this number some 75 per cent are insured through their employer, who pays all or a large part of the premium.

To a great extent industry's participation in the financing of health care for its employees has been a post-World War II development. Appearing on the horizon as a "fringe benefit" during labor-management negotiations, this coverage has increased in scope until today it has become a major concern to management, especially with the continued rise in hospital costs. In many programs for the health care of industrial workers the commercial carrier acts only as a fiscal agent on a cost-plus basis. Claims control in these instances is definitely a more difficult problem than in Blue Shield, where appropriate committees from the local medical society help

by reviewing utilization. Service contracts available through our West Virginia Blue Shield Plans are another attraction to the mass purchaser of medical care. It is quite possible there could be a sizable return to Blue Shield coverage by industry in the near future if good national contracts could be worked out between our Plans.

At this time approximately 17 per cent of West Virginians are insured in Blue Shield. The enrollment today is just a little less than it was in 1955, but during this period (between 1955 and 1964) the percentage of our citizens covered by some type of health insurance has increased from 64 to 76.8 per cent.

We still have seven Blue Shield Plans operating in West Virginia, with a combined enrollment on December 31, 1962, of 297,477. Charleston and Huntington Blue Cross Plans have merged into one but the two Blue Shield Plans remain separate entities but under single administration. The enrollment of Charleston, Huntington and Bluefield in the southern part of the state totals 166,058. The number of members in the Clarksburg, Morgantown, Parkersburg and Wheeling Plans totals 131,149.

Certainly it is conceivable that unification of these seven Plans would increase efficiency of operation and make easier the writing of national contracts. These are definite needs if our physician-sponsored voluntary prepayment medical benefit plans are to survive. Exploration of the possibility of complete unification of all West Virginia Blue Shield Plans leads one to the conclusion that at this time such a proposition would have no more chance than it did in 1955 when the Insurance Commissioner, Mr. Thomas Gillooly, attempted unity via legislation.

The time may be right to consider a more possible solution which would be the formation of a Northern and Southern Plan. The merger of Bluefield and Charleston would complete the Southern Plan. Consolidation of Clarksburg, Morgantown, Parkersburg and Wheeling to form a Northern Plan might require considerable more negotiation, but seems within the realm of possibility. Unification or not, it certainly is imperative that the various Plans adjust their contracts and benefits to a semblance of uniformity if Blue Shield is to attract national contracts in West Virginia.

A two-year study has been completed by the Joint Committee on Government and Finance and the Commission on Interstate Cooperation of the West Virginia Legislature as to the feasibility of the State providing medical and hospital services for those persons qualified to receive such care from medical care corporations. Many legislators have expressed their interest in this study. Should legislation be passed whereby Blue Cross—Blue Shield Plans of West Virginia were to become agents of the Department of Welfare in providing medical care for qualified persons, this would be a large undertaking. All Blue Plans have expressed their willingness to cooperate in such a venture and plans are being made toward such a possibility.

(Ed. The Publication Committee invites comments on this editorial and the article by Dr. Russell B. Carson [Page 15]. Letters addressed to the Editor will be published in subsequent issues of *The Journal*).

THE FUTURE SUPPLY OF PHYSICIANS

With the rapid growth of the population in the United States practitioners of medicine are becoming increasingly interested in the future supply of physicians. Not only physicians are interested in this problem but many others as well; indeed it is a problem of national interest.

A recent datagram (August, 1964), distributed by the Association of American Medical Colleges, calls attention to the report made in 1959 by the Surgeon General Consultant Group on Medicine. This group recommended that by the year 1975 medical schools should produce 10,400 graduates. In order to supply this figure, in 1971 (if the present attrition rates continue) 11,000 students must be admitted to our medical schools.

In the autumn of 1963, 8,754 first year students enrolled in our medical schools. Thus, over the next seven years the medical schools of the United States must provide nearly 3,000 more first year places then presently exist. This can be accomplished in two ways: (1) by the creation of new schools (either two or four year programs), and (2) by expansion of existing schools.

Presently there are 12 new medical schools in the process of development. Five of these expect to offer the first two years of the medical curriculum; these are: University of New Mexico, Rutgers University, Michigan State University, Hawaii, and Brown University. Seven schools plan to offer the regular four year curriculum; these are: University of Arizona, University of California at San Diego, University of Connecticut, Pennsylvania State University, University of Massachusetts, Mount Sinai Hospital, New York, and the University of Texas at San Antonio.

It is estimated that these twelve new schools will afford places for approximately 800 first year

places; leaving about 2,200 new first year places still needed. This is a formidable figure and presents serious problems. Presumably most of the well-established four-year schools are able to accept more students, but great care must be exercised so that the present high quality of medical teaching and research will be preserved.

One possible approach to the problem would be for some of the four-year schools to admit classes twice a year, for example, in September and April. If this were done, the teaching staff would have to be augmented, the operating budget materially increased, and some new construction for housing an increased number of teachers undoubtedly would be needed.

More physicians apparently are needed, because many graduates of foreign medical schools are entering the United States each year. Rappleye[1] has recently pointed out that about 19 per cent of physicians licensed to practice medicine in the United States last year were graduates of foreign medical schools. He mentions further that about one-third of all interns and residents in the United States are graduates of foreign medical schools.

Rappleye also emphasizes that graduates from leading European institutions are well trained and competent. But a large proportion of those now coming into the United States who are graduates of non-European schools are prepared below educational standards regarded as satisfactory in this country. It might be added that many of these foreign graduates are badly needed in their own country.

In the final analysis, the United States should not have to depend upon other countries to supply physicians. Long range plans should be made so that a sufficient number of medical students can be trained to meet the needs of our growing population.

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1. Rappleye, W. C.: "Emerging Patterns of American Medicine," the Alpha Omega Alpha lecture at the College of Physicians and Surgeons, New York, May 13, 1964, pp. 7-8.

Of Vital Importance!

It is of vital importance that you take the time to complete and return the questionnaire which appears in the *News Section* of this issue of *The Journal.*

Your prompt participation in this readership survey will serve as a guide to help us produce an even better *Journal* in the years ahead.

Let us hear from you!

The Publication Committee

GENERAL NEWS

Dr. James Z. Appel Named AMA President Elect

Dr. James Z. Appel of Lancaster, Pennsylvania, was named President Elect of the American Medical Association during the 19th Annual Clinical Convention held in Miami Beach, Florida, November 29-December 2.

Doctor Appel, Vice Chairman of the AMA Board of Trustees and a member of the Board since 1957, will be installed as President at the Annual Meeting in New York City in June. He will succeed Dr. Donovan F. Ward of Dubuque, Iowa, who took office after the death of Dr. Norman A. Welch.

Tribute was paid to the late Doctor Welch, who died on September 3, in a memorial statement from the Massachusetts Medical Society and in a resolution adopted by the House.

State Delegates Attend Meeting

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington, AMA delegates from West Virginia, were in attendance at all sessions of the House during the three-day meeting. Doctor Holroyd served as a member of the Reference Committee on Insurance and Medical Service.

Also attending the meeting in Miami Beach were Dr. Albert C. Esposito of Huntington, President of the State Medical Association; Dr. Seigle W. Parks of Fairmont, President Elect; and Dr. D. E. Greeneltch of Wheeling, AMA Alternate Delegate.

Summary of Miami Beach Meeting

The following summary of the Miami Beach meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

Health care for the aging, a new teletype communications system for the medical profession, a statement on human reproduction and recommendations from the Commission on the Cost of Medical Care were among the major subjects acted upon by the House of Delegates during the Clinical Convention.

Health Care for the Aging

Definitive action on the issue of health care for the aging came with the House of Delegates' strong endorsement of Doctor Ward's address, in which he declared that "We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

Dr. Richard W. Corbitt of Parkersburg, right, Chairman of the State Medical Association's Committee on the Medical Aspects of Sports, is shown with Dr. Tenley Albright of Boston during a session of the Sixth National Conference on the Medical Aspects of Sports in Miami Beach on November 29. Doctor Albright, former Olympic figure skating star, presented a paper on 'Sports for Girls.'

Reaffirming the Association's opposition to the King-Anderson type of legislation, Doctor Ward said:

"If we have been right in the past—and that is our unshakeable belief—then we are right today. And we shall be right tomorrow."

Calling for renewed, intensive effort to prevent the passage of such legislation, he pointed out that "we do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

Doctor Ward, expressing pride in the medical profession, concluded his address with these statements:

"I pray that we all gain strength for renewed effort by the simple reflection that what we are doing is worthwhile—that if the effort is great the results of not making the effort would be unthinkable—and, finally, what we are doing is vastly more important than ourselves.

"No more can be asked of us as citizens. No less should be offered by us in guarding our heritage of freedom."

To implement the ideas in Doctor Ward's address, the House gave unequivocal approval of a Board of Trustees suggestion that an expanded educational program be conducted in the next few months. In asking

Dr. Albert C. Esposito of Huntington, left, President of the West Virginia State Medical Association, led a group of West Virginia physicians who attended a luncheon meeting of the Aces and Deuces organization in Miami Beach. He is shown with Drs. Seigle W. Parks of Fairmont, Frank J. Holroyd of Princeton, Richard W. Corbitt of Parkersburg and AMA Field Representative Harry R. Hinton of Chicago.

for this approval, the Board pointed out that "a variety of techniques and media must be utilized if the public, the Congress and special audiences are to be reached effectively."

The House took no action on three resolutions which would have altered the AMA position on health care legislation. Instead, the House adopted a resolution which urged "component associations to stimulate the state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care will be available."

The state medical societies also were urged to send representatives to two conferences related to the issue of health for the aging. One was held on December 13 to help plan the new educational program and the other is on January 9-10, 1965, to consider further implementation and expansion of the Kerr-Mills programs.

Teletype Communications System

The House approved a recommendation from the Board of Trustees for establishment of a teletypewriter communications service between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications between AMA Headquarters and all participating state societies, and between the state societies without involving the facilities at the AMA Headquarters. The system also will enable any state society to communicate with all other TWX subscribers in the United States and Canada.

In approving the recommendation, the House emphasized that participation is optional with the state medical societies but it also urged each society to "seriously consider taking advantage of this rapid communications system." Installation and rental costs for the teletype equipment, both at AMA Headquarters and at the headquarters of each participating medical society, will be paid by the AMA. The cost of transmitting messages will be paid by whichever organization originates each message. It is hoped that the new communications system will become operative no later than July 1965.

Human Reproduction

Updating its policies on population control, "to conform to changes in society and medicine" and to "take a more positive position on this very important medical-socio-economic problem," the House adopted the following four-point statement:

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it is a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

In taking the action, the House also recommended that the AMA cooperate with the appropriate voluntary

organizations in the field of human reproduction which have adequate medical direction.

Commission on the Cost of Medical Care

With modifications suggested by the Board of Trustees, the House approved 33 recommendations from the Commission on the Cost of Medical Care. The suggestions had been rearranged by the Board into four sections—Research, Hospitals, Physicians and Miscellaneous. In accepting the Board report, the House also rejected a floor amendment which recommended that a medical advisory committee composed of practicing physicians be appointed to supervise the several studies which were suggested.

In presenting its conclusions and recommendations to the Board of Trustees, the Commission on the Cost of Medical Care expressed the hope "that the recommendations which are approved will help promote the wisest possible use of the medical care dollar and aid in the development of more meaningful data on the cost of medical care."

The House learned that a substantial number of the studies recommended by the Commission are already under way and that others are in the process of being implemented. The House also emphasized its appreciation cf the importance of these continuing studies and urged that adequate funds be provided for maximum implementation of the recommendations.

Miscellaneous Actions

In considering a wide variety of annual reports, special and supplementary reports and resolutions, the House also:

Amended the Bylaws to permit the presidential inauguration to take place at a time other than Tuesday evening and approved a suggestion that the inaugural ceremony at the 1965 Annual Convention be held on Sunday, June 20;

Amended the Bylaws to permit presentation of the AMA Distinguished Service Award at a time to be determined by the Board of Trustees and learned that the Board wishes to present this award at the Scientific Awards Dinner;

Agreed that the AMA should cooperate with the U. S. Public Health Service in eradicating the Aedes aegypti mosquito from the American hemisphere;

Urged strong support of the Woman's Auxiliary and asked state and county medical societies to give serious consideration to the idea of joint husband-wife membership;

Agreed that a Section on Space Medicine should not be created at this time;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, non-deductible contribution to independent political action committees on the society's annual dues billing statement;

Approved a Board recommendation that the 1967 Clinical Convention be held in Houston, Texas;

Agreed with the Board that there should not be an increase in AMA dues at this time;

Reaffirmed its approval and support of the National Council for Accreditation of Nursing Homes and

Instructed the Board to re-evaluate the mission of the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported to the House that one out of every six medical students, interns and residents in the U. S. is now receiving financial assistance from the Foundation's loan fund. The AMA-ERF also announced that Merck Sharp & Dohme pharmaceutical company has made its fourth $100,000 contribution to the loan fund and has pledged an additional $100,000 in 1966.

Final registration at the convention reached a total of 9,356, including 4,118 physicians.

Dr. Robert C. Hood Named Director Of Berkeley-Morgan Health Dept.

Dr. Robert C. Hood, a native of Weston, has been named full-time health officer for Berkeley and Morgan Counties in West Virginia's Eastern Panhandle.

Doctor Hood, who is now residing in Martinsburg, practiced in Arlington, Virginia, before assuming his present post. He graduated from Washington and Lee University and received his M. D. degree in 1916 from the Johns Hopkins University School of Medicine.

He practiced in Clarksburg for a number of years and served as second vice president of the West Virginia State Medical Association. He later was appointed Director of Maternal and Child Health Services for the State of Florida and served as Director of Crippled Children's Services for the Department of Labor in Washington, D. C.

Speakers Named for Oph. and Otol. Meeting at The Greenbrier

The 18th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 18-21.

The committee in charge of arrangements has announced that six prominent physicians have accepted invitations to appear as guest speakers.

Drs. Arthur G. DeVoe of New York City, Philip M. Lewis of Memphis, Tennessee, and Nathan S. Schlezinger of Philadelphia will present papers on ophthalmology.

Drs. David Austin of Chicago, Edwin W. Cocke of Memphis and T. Manford McGee of Detroit will present papers on otolaryngology.

Additional information concerning the meeting may be obtained by writing the secretary, Dr. Worthy W. McKinney, Professional Park, Beckley, West Virginia.

Dr. H. C. Ballou Chairman of SMA Section on Industrial Medicine

Dr. H. C. Ballou of White Sulphur Springs was named Chairman of the Section on Industrial Medicine and Surgery of the Southern Medical Association during the 58th Annual Meeting, which was held in Memphis, Tennessee, November 16-19.

Doctor Ballou succeeds Dr. William L. Macon, Jr., of St. Louis.

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association and immediate past chairman of the SMA's Section on Ophthalmology, was reelected to the organization's Executive Committee and to the Executive Committee of the Section on Ophthalmology. Doctor Esposito also serves as Councilor from West Virginia.

Doctor Galbraith Named President Elect

Dr. J. Garber Galbraith of Birmingham, Alabama, was named SMA president elect. He will be installed at the 1965 meeting which will be held in Houston, Texas, November 1-4. He will succeed Dr. R. H. Kampmeier of Nashville, Tennessee, the current president.

The meeting featured three special symposiums on "Drug Therapy, Clinical Pharmacology and Reaction to Drugs," "Current VD Problems," and "Problems of Adolescents."

Doctor Esposito presented a paper on "The Role of General Anesthesia in Cataract Surgery" before the Section on Ophthalmology. Dr. S. D. Wu of Philippi presented a paper on "Contemporary, Multiple Major Diseases" before the Section on Pathology and Drs. Michael M. Klein and Robert L. Bradley of the Huntington VA Hospital presented a paper on "Gastrospasm in Gastric Ulcer" before the Section on Radiology.

New $2.2 Million Cleveland Clinic Education Building Dedicated

Dr. Edward R. Annis of Miami, Florida, immediate past president of the American Medical Association, was the guest speaker at the dedication of a new $2.2 million Education Building at the Cleveland Clinic in Cleveland, Ohio, in November.

The building will be the scene for the dozen or more two-day postgraduate courses which the Clinic gives each year for practicing physicians in the United States and Canada.

In his address, Doctor Annis said that "One doctor trained in this great Clinic will go out and detect and prevent more disease and do something about it when he finds it, than my whole class of 56 when we graduated from medical school 26 years ago."

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Status of Bills Reported In Legislative Bulletins

Complete reports concerning action by the Legislature on bills of interest to the medical profession are incorporated in "Legislative Bulletins" that will be sent frequently to members of the Association. The 60-day session opens January 13.

The Bulletins that will be mailed from the headquarters offices of the State Medical Association are timed so as to take advantage of report dates by key committees and subsequent action by the Senate and House of Delegates.

Through the use of Bulletins, we will continue to bring to our members as promptly as possible up-to-the-minute activities. These reports are, in effect, news stories that are being prepared and distributed in lieu of lengthy stories that would ordinarily appear in *The Journal.*

The final Bulletin will be mailed within a day or two after adjournment of the Legislature on March 13.

New Association Members

Dr. Miguel F. Beruben, Madison General Hospital, Madison (Boone). Doctor Beruben was born in Mexico and received his medical education in that country. He interned at Civil Hospital in Mexico and served residencies at Grace Hospital in Cleveland and Madison General Hospital, 1958-64. He served as a Major in the Mexican Army and he is engaged in general practice.

* * * *

Dr. John DeLisio, 1001 Third Street, Moundsville (Marshall). Doctor DeLisio, a native of Boston, received his M. D. degree in 1938 from the University of Rome in Italy. He interned at St. Bernard's Hospital in Chicago and served a residency at Brewster Hospital. He was licensed to practice in West Virginia in 1963 and was previously located at the VA Hospital in Beckley. His specialty is pulmonary diseases.

* * * *

Dr. Robert E. Dye, Grace Hospital, Welch (McDowell). Doctor Dye, a native of Eckman, McDowell County, was graduated from Duke University and received his M. D. degree in 1958 from the University of Virginia School of Medicine. He interned at Cornell-New York Hospital, 1958-59, and served residencies at that hospital and the University of Virginia Hospital, 1959-63. He served with the U. S. Army, 1951-53, and his specialty is internal medicine.

* * * *

Dr. James V. Gainer, Jr., 148 Main Street, Kingwood (Preston). Doctor Gainer, a native of Kingwood, attended the two-year WVU School of Medicine and

received his M. D. degree in 1959 from Jefferson Medical College. He interned at the U. S. Naval Hospital in Philadelphia, 1959-60, and served for four years as a Lieutenant in the Medical Corps of the U. S. Navy. He is engaged in general practice.

* * * *

Dr. J. Samuel Griffith, P. O. Box 206, Wayne (Cabell). Doctor Griffith, a native of Charleston, attended the WVU School of Pharmacy and received his M. D. degree in 1962 from the WVU School of Medicine. He interned at Charleston General Hospital, 1962-63, and he served for four years in the U. S. Air Force. He was previously located in Williamson and he is engaged in general practice.

* * * *

Dr. Arthur W. Haelig, Appalachian Regional Hospital, Beckley (Raleigh). Doctor Haelig, a native of Chicago, was graduated from the University of Chicago and received his M. D. degree in 1952 from the Columbia University College of Physicians and Surgeons. He interned at Barnes Hospital in St. Louis, 1952-53, and served a residency at the University of Chicago Hospital, 1954-56. He also had postgraduate work at the University of Pittsburgh, 1953-54. He served with the U. S. Navy, 1945-46, and was formerly located in San Mateo, California. His specialty is internal medicine.

* * * *

Dr. Thomas C. Howes, 198 Spruce Street, Morgantown (Monongalia). Doctor Howes, a native of Marlinton, attended the two-year WVU School of Medicine and received his M. D. degree in 1960 from the Medical College of Virginia. He interned at Charleston Memorial Hospital, 1960-61, and served for 27 months as a Captain in the Medical Corps of the U. S. Air Force. He is engaged in general practice.

* * * *

Dr. Jerry G. Liepack, 800 Fifth Street, Moundsville (Marshall). Doctor Liepack, a native of Wheeling, was graduated from Washington and Jefferson College and received his M. D. degree in 1961 from the University of Pittsburgh School of Medicine. He interned at the Southern Pacific General Hospital in San Francisco, 1961-62, and served as a surgeon in the Veneral Disease Section of the U. S. Public Health Service. He is engaged in general practice.

* * * *

Dr. Antonio Martinez, 1106 Virginia Street, E., Charleston (Kanawha). Doctor Martinez was born in Cuba and received his M. D. degree in 1946 from the Havana University Medical School. He interned at Danbury Hospital at Danbury, Connecticut, 1947-48, and served a residency at Jefferson Hospital in Philadelphia, 1949-51. He formerly practiced in Cuba and he is a member of the Cuban Medical Society in Exile. His specialty is ophthalmology.

* * * *

Dr. Wallace B. Murphy, Blueville Addition, Grafton (Taylor). Doctor Murphy, a native of Grafton, attended the two-year WVU School of Medicine and received his M. D. degree in 1930 from the New York University School of Medicine. He interned at Bellevue Hospital and had postgraduate work at New York University. He served as a Lieutenant Commander on active duty with the Medical Corps of the U. S. Navy for more than 3½ years and for 20 years in the Reserve. He was previously located in New York City and his specialty is general surgery.

* * * *

Dr. Jose A. Pagan, 201 W. Raymond Avenue, Pennsboro (Parkersburg Academy). Doctor Pagan was born in Puerto Rico and received his M. D. degree in 1950 from the University of Puerto Rico School of Medicine. He interned at the Wayne County General Hospital in Eloise, Michigan, 1950-51, and served as a First Lieutenant in the U. S. Army, 1952-55. He was formerly located at Man Memorial Hospital and he is engaged in general practice.

* * * *

Dr. Basil P. Papadimitriou, 100 Seventh Street, Wellsburg (Brooke). Doctor Papadimitriou was born in Corinth, Greece, and received his M. D. degree in 1953 from the University of Athens. He interned and served a residency at Wheeling Hospital, 1957-64. He served as an Ensign in the Greek Navy and is engaged in general practice.

* * * *

Dr. Ruth Marjory Phillips, 426 Medical Center Drive, Morgantown (Monongalia). Doctor Phillips, a native of Johannesburg, South Africa, was graduated from Mt. Holyoke College and received her M. D. degree in 1948 from the Johns Hopkins University School of Medicine. She interned at Vancouver General Hospital in Canada, 1948-49, and served a residency at Johns Hopkins Hospital. She served as pediatrician-in-charge of the pediatric out-patient department, 1952-53, and then served as chief resident and fellow in tumor chemotherapy at Children's Medical Center in Boston. She also served as an instructor in pediatrics at the Boston University School of Medicine. She is currently serving as Assistant Clinical Professor of Pediatrics at the WVU School of Medicine.

* * * *

Dr. R. E. Walden, Lakin State Hospital, Lakin (Mason). Doctor Walden, a native of Boston, was graduated from Lincoln University and received his M. D. degree in 1945 from Meharry Medical College. He interned and served a residency at Kansas City General Hospital No. 2, 1946-47, and had postgraduate work at the VA Hospital in Brockton, Massachusetts, 1957-60. He served with the U. S. Army, 1943-45, and was a Captain in the Medical Corps of the U. S. Air Force, 1953-55. He was previously located at the VA Hospital in Pittsburgh and is currently serving as Superintendent at Lakin State Hospital.

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

Births Declined, Deaths Increased In West Virginia During 1963

West Virginia recorded fewer births and more deaths during 1963 than in any comparable period for several decades. State Director of Health Dr. N. H. Dyer, in his weekly State of the State's Health, discussed significant statistics from the 1963 Vital Statistics Report.

He pointed out that the total of 35,573 births in the State was nearly double the number of deaths, yet this was the lowest number since 1921 when the figure was 32,038. On the other hand, the 19,405 deaths for 1963 represent the highest figure since 1936.

These 35,573 resident live births represent a birth rate of 20.0 births per 1,000 population, slightly below the 21.6 provisional rate for the United States and the 1962 State rate of 21.0.

Heart Disease Chief Cause

The 19,405 resident deaths represented a rate of 10.9 deaths per 1,000 population, slightly higher than last year's rate of 10.5 and considerably higher than the provisional death rate of 9.6 for the United States. Median age at death in 1963 was 69.3 years, a drop from the 1962 figure of 69.9, but still ahead of 1961's 68.9.

Leading causes of death included:

1. Diseases of Heart, 7,606 deaths, 39.2 per cent.
2. Malignant Neoplasms (cancer), 2,674 deaths, 13.8 per cent.
3. Vascular Lesions Affecting Central Nervous System (strokes), 2,164 deaths, 11.1 per cent.
4. Accident, 1,167 deaths, 6.0 per cent.
5. Pneumonia and Influenza, 946 deaths, 4.9 per cent.
6. Diseases of Early Infancy, 537 deaths, 2.8 per cent.
7. General Arteriosclerosis, 394 deaths, 2.0 per cent.
8. Diabetes Mellitus, 320 deaths, 1.6 per cent.
9. Other Diseases of the Circulatory System, 232 deaths, 1.2 per cent.
10. Congenital Malformations and Hypertension without Heart, 215 deaths each, 1.1 per cent each.

Suicide Dropped from Top Ten

Suicide, the ninth leading cause of death during 1962, dropped out of the top ten during 1963. Diseases of early infancy, not on the 1962 list, was the sixth leading cause during 1963.

Of 1,167 accidental deaths, an increase of 31 over 1962, motor vehicles accounted for 439. But the greatest number, 675, were non-transport accidents. The largest number, 219, took place in the home. Only 27 occurred at an industrial site.

Falls accounted for 184 of the non-transported accidental deaths with fire and explosion of combustible materials accounting for the second largest single number, 119. Falls also caused the greatest number of home accident deaths, 80, with fire and explosion second, 73, and poisoning third with 21 deaths.

There were 4,576 males who died from chronic rheumatic heart disease, arteriosclerotic and degenerative heart disease, hypertension without heart disease and other diseases of the heart while these same diseases took 3,023 female lives. Likewise, cancer took a greater number of male lives, 1,487, against female, 1,187. Tuberculosis deaths totaled 151 with a rate of 8.5 deaths per 100,000 population. This is five more than 1962's total of 146.

Among deaths resulting from acute communicable diseases, syphilis accounted for 34, a decrease of 4 from 1962. There were two poliomyelitis deaths, one more than the year before. There were 34 diarrhea and enteritis deaths, two less than in 1962. Infective and parasitic diseases killed 261, an increase of 16 over 1962. There were seven measles deaths compared to three the year before.

Jerry Gould Resigns To Join AMA Field Service Staff

Jerry Gould of Charleston, assistant to the executive secretary of the West Virginia State Medical Association, has resigned to accept a position with the staff of the Field Service Division of the American Medical Association.

Jerry Gould

Mr. Gould served on the staff of the State Medical Association for 2½ years prior to assuming his new duties with the AMA on January 1. His headquarters will be in Chicago and he will serve as field representative for the states of Alabama, Tennessee, Mississippi and Florida.

Prior to joining the staff of the State Medical Association in 1962, Mr. Gould had served for five years as a member of the staff of United Press International in Charleston. He also served for 11 years as a general and sports reporter for newspapers in Charleston and Parkersburg.

He is married to the former Jean Ann Smoot, a registered nurse, and they have eight children.

Medical Meetings, 1965

The following is a partial list of national, state and district medical meetings scheduled for 1965:

Jan. 11-13—Medical Licensing Board, Charleston.
March 26-27—National Rural Health Conference, Miami Beach.
Apr. 18-21—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Wheeling.
May 9-14—Ohio State Medical Assn., Columbus.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 22-24—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.

Officers of the West Virginia State Medical Association and members of the Workmen's Compensation subcommittee met with Compensation Commissioner Cletus B. Hanley in Charleston on December 9. The meeting served to develop closer liaison between the State agency and the Association and additional meetings will be held in the near future for further discussion of mutual problems.

Those attending the meeting from the Association were, left to right, Drs. J. C. Pickett of Morgantown; Henry M. Hills, Jr., and George R. Callender, Jr., of Charleston; Albert C. Esposito of Huntington, President; Milton J. Lilly, Jr., of Charleston; Charles L. Goodhand of Parkersburg, Chairman of Council; and Kenneth G. MacDonald of Charleston.

AMA Emergency Identification Symbol Adopted by WMA

The emergency medical identification symbol sponsored by the American Medical Association for universal use was adopted by the Assembly of the World Medical Association at its meeting in Helsinki, Finland, in June, 1964.

The resolution stated "that this symbol . . . be adopted by the World Medical Association as the universal emergency medical information symbol, and that its use on identification tags, bracelets and cards be encouraged among the people of the world."

International travellers wearing the universal symbol as an indicator of their special needs in an emergency, will soon have it recognized for what it is in the 58 member nations of the WMA. This is a significant advance in international cooperation for health protection.

Further information about the symbol and its use may be obtained by writing to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois, 60610.

Relocation

Dr. Seigle W. Parks, who practiced medicine in Fairmont since 1942, has accepted appointment as full-time medical director of the Chesapeake and Potomac Telephone Company of West Virginia. He assumed his duties in Charleston on December 21. Doctor Parks is President Elect of the State Medical Association.

Behind every new drug that has reached the public in the past decade, it is estimated that the industry has spent $4 million in research and development.

12 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board licensed 12 physicians by reciprocity at a meeting held at The Capitol in Charleston on October 19, 1964. The following is a list of the physicians who were licensed:

Blevins, Joseph Wendell, Hannibal, Ohio
Gretter, Thomas Edward, Morgantown
Isaacs, Charles Thomas, Morgantown
Jarvis, Marilyn Anderson, Morgantown
Neville, Edwin Charles, Charleston
Perras, David Arthur, Williamson

Prince, Loren Carter, Columbus, Ohio
Swanson, Roy A. L., Morgantown
Thompson, Hartwell Greene, Jr., Morgantown
Varney, Frank Thomas, Stone, Kentucky
Wimsatt, William Anthony, N. Syracuse, N. Y.
Harlow, Gene William, Pineville

The next meeting of the Medical Licensing Board will be held at The Capitol in Charleston, January 11-13, 1965, for the purpose of examining physicians by direct examination and by reciprocity.

PG Course in Dermatology

The Mound Park Hospital Foundation will present a postgraduate course on "Dermatology in General Practice" at the Bay Pines VA Center in St. Petersburg, Florida, January 14-16.

Members of the American Academy of General Practice will be granted 18 hours of credit for attendance at the three-day session. The registration fee is $40 and further information may be obtained by writing to the Mound Park Hospital Foundation, Inc., St. Petersburg, Florida, 33701.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

LOMOTIL fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

THE appointment of Dr. Predrag J. Jurcic as an Instructor in Surgery in the Division of Ophthalmology at the West Virginia University School of Medicine has been announced by Dean Clark K. Sleeth.

Doctor Jurcic received his training at universities and hospitals in seven countries — Yugoslavia, Norway, Sweden, Great Britain, Germany, Canada and the United States.

Predrag J. Jurcic, M. D.

He is a native of Cakovec, Yugoslavia, and was an exchange student in Norway, Sweden, Great Britain and Germany, 1955-57. He received his M. D. degree in 1958 from the University of Zagreb School of Medicine in Yugoslavia.

He served an internship in England and completed a residency in ophthalmology at the Montreal General Hospital in Montreal, Canada, before joining the WVU faculty.

Nine Seminars on Cancer Research

Four of nine seminars on cancer research were held during the months of October, November and December at the WVU Medical Center under the supervision of Dr. Alvin L. Watne, Associate Professor of Surgery and Cancer Coordinator.

Doctor Watne said the seminars were developed under the direction of Dr. Henry Mengoli, Instructor and Head of the Cancer Research Laboratory.

The remaining seminar schedule is as follows:

January 14—"Immunology of Cancer," Mr. Fred Hymes, Fellow in Biochemistry.

February 18—"Unusual Immune Responses in Tumor-Bearing Host," Ernest W. Chick, M. D., Director of Preventive Medicine.

March 18—"Chorionepithelioma—A Human Tumor of Unique Inception and Immunological Properties," Antonio Palladino, M. D., Instructor in Obstetrics and Gynecology.

April 15—"Skin Cancer and Reaction to Local Cytotoxic Agents," William A. Welton, M. D., Assistant Professor and Chairman of Dermatology.

May 13—"Unusual Aspects of Human Cancer," Victor M. Napoli, M. D., Assistant Professor of Pathology.

• Compiled from material furnished by Arthur V. Cierva, Director, Medical Center News and Information Services, Morgantown, West Virginia.

All seminars are scheduled at 7 P. M. in Room 2116 of the Medical Center. Doctor Mengoli is the moderator.

Joins Husband on Staff

Dr. Chung Sook Chun recently joined her husband on the staff of the WVU School of Medicine. She accepted an appointment on December 1 as an Instructor in Pediatrics. Her husband, Dr. C. H. Joseph Chang, is an Associate Professor of Radiology.

Doctor Chun is a native of Hamnam, Korea, and received her M. D. degree in 1953 from Severance Union Medical College in Seoul, Korea.

Before joining the WVU faculty, Doctor Chun served as Associate Chief of Pediatrics at the Appalachian Regional Hospital in Man. She is certified by the American Board of Pediatrics.

$10,000 Tuberculosis Grant Renewed

The West Virginia Tuberculosis and Health Association recently renewed for the fifth consecutive year a $10,000 pulmonary disease chair at the WVU School of Medicine.

Mr. Jerry McDevitt of Princeton, President of the Association, made the presentation to WVU Vice President Dr. Kenneth E. Penrod in Morgantown on November 15.

Dr. Charles E. Andrews, Associate Professor of Medicine, occupies the chair sponsored by the Association.

Resident Receives Fellowship

Dr. Eugene S. LaPlante, a resident in surgery at the University Medical Center, was recently awarded a $3,600 Clinical Fellowship by the American Cancer Society for 1964-65.

The fellowships, which provide specialized training in cancer diagnosis and treatment, are awarded at mid-year to 245 young physicians and dentists in residency training programs at medical and dental schools throughout the nation.

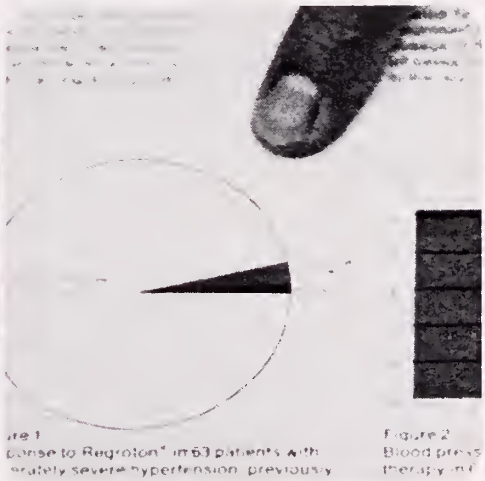
Doctor LaPlante is a native of Fulda, Minnesota, and received his M. D. degree in 1962 from the University of Minnesota Medical School.

s new at Geigy? Regroton, Doctor.
gh blood pressure.

Not *another* reserpine-diuretic combination!

Certainly. Regroton has outperformed other combinations.

who?

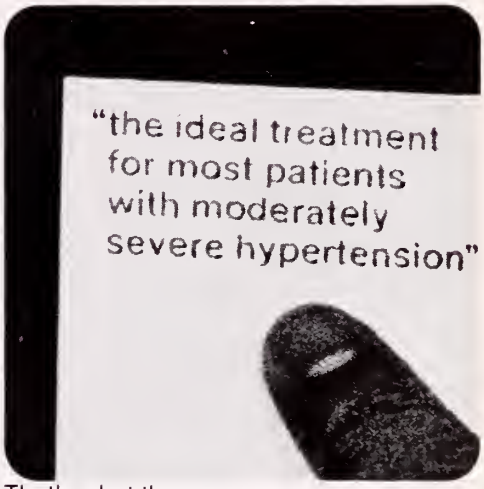


Says this 2-year study by Finnerty.

What's the dosage?

one tablet with breakfast.

Sounds ideal!



That's what they say.

sition: Each tablet contains chlorthalidone, , and reserpine, 0.25 mg.
indications: History of mental depression, ensitivity, and most cases of severe renal atic diseases.
ng: Discontinue 2 weeks before general esia, 1 week before electroshock therapy, depression or peptic ulcer occurs.
utions: Reduce dosage of concomitant anti-ensive agents by one-half. Discontinue if IN rises or liver dysfunction is aggravated. olyte imbalance and potassium depletion ccur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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egroton® "the ideal treatment for most patients with moderately severe hypertension"*

Geigy

The Month in Washington

THE Food and Drug Administration has started enforcing the prescription drug advertising provisions of the new law. Sales of ethical drugs are now exceeding $2 billion a year in the United States. The Bureau of the Census reported ethical drug sales at $2.05 billion in 1963, the first year that they had gone over the $2 billion mark. The Pharmaceutical Manufacturers Association's figure was $2.39 billion.

The law requires that prescription drug advertisements show:

—The "established name" of the drug, if one exists, in type at least half as large as that used for the brand name;

—The drug's quantitative formula, and

—A true and non-misleading brief summary of information about adverse side effects, contraindications, and effectiveness of the drug for the guidance of physicians.

Monitoring Journal Advertising

In enforcing these requirements, FDA said it would seek to determine whether a fair balance exists between the information on effectiveness and that on side effects and contraindications. The FDA's Bureau of Medicine has started monitoring professional journal advertising for prescription drugs. It will forward violative advertisements with appropriate recommendations to the FDA Bureau of Regulatory Compliance.

Dr. Joseph F. Sadusk, Jr., Medical Director of FDA, said that it is the duty of physicians to keep fully informed of the composition, mode of action, efficacy and potential toxicity of drugs because as the potency of drugs increases, "so generally does their complexity and their potentiality for harm."

Violations of prescription drug advertising will be evaluated in two categories:

—Positive claims or omissions concerning the product which present potential danger to the patient in varying degrees. Examples include omission of some of the pertinent side effects, precautions or contraindications; improper statements about the effectiveness of, or indications for, the drug or antibiotic; omission of some of the information on various dosage forms, ingredients, or directions for use where required.

—Claims which may or may not involve danger to patient health but which, in the selling message, can seriously mislead as to the proper place of the drug or antibiotic in the total spectrum of products available to meet a specific disease situation.

• **From the Washington Office of the American Medical Association.**

FDA Orders Label Changes

The American Medical Association and the Food and Drug Administration have warned that two fever and pain-relieving drugs are causing fatal agranulocytosis, a blood disorder, in some patients.

The drugs are aminopyrine and dipyrone, closely related compounds which have been dispensed widely by prescription for many years. Drastic label changes restricting the recommended uses for the drugs were announced by FDA. An editorial supporting the FDA action was carried in the AMA's journal, JAMA.

The FDA ruling was based on case reports collected by AMA and on recommendations of a special committee of medical experts in the fields of hematology, internal medicine, neurology, pediatrics and pharmacology.

Hospital Use Increases

Nearly one million more people were admitted to hospitals in the U.S. in 1963 than in the previous year, according to the Health Insurance Institute.

The Institute said that American Hospital Association statistics showed a record 25,267,000 Americans, or one of every seven, were hospitalized last year. This represented an increase of 960,000 over 1962. This meant that each day more the 69,000 persons entered non-federal short-term general and other special hospitals, and that on an average day in 1963 there were 530,000 patients—2.8 persons per 1,000 population—under hospital confinement.

There were 698,000 beds available for patients in 1963, an average of 3.7 beds per 1,000 population.

The AHA, which includes terminal hospitalizations in its survey, found the average hospital stay for all ages to be 7.7 days. A study conducted by the U.S. National Health Survey, which included federal hospitals, and was based on representative household interviews, put the average hospital stay at 9.4 days. It did not include terminal hospital stays.

The NHS report showed that persons with health insurance protection averaged shorter hospital stays than those with no insurance protection at all. This may indicate, the report suggested, that persons with health insurance protection will seek hospital care more often for diagnosis or for less serious illness than the uninsured.

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PSYCHIATRY FOR THE MEDICAL PRACTITIONER

New Orleans, Louisiana, March 4-6, 1965

Sponsored by the DIVISION OF NEUROLOGY AND PSYCHIATRY OF TOURO INFIRMARY under a National Institute of Mental Health Grant.

GUEST LECTURERS INCLUDE:

Jack Ewalt, M. D., Prof. of Psychiatry, Harvard Med. School, Past Pres. of American Psychiatric Association Boston, Mass.

John Lambert, M. D., Medical Director, Four Winds Hospital, Washington D. C.

Zigmond Lebensohn, M. D., Chief, Dept. of Psychiatry, Sibley Memorial Hospital, Washington, D. C.

William Sheeley, M. D., Director of Psychiatry & Medical Practice Project of the A. P. A., Washington, D. C.

Philip Solomon, M. D., Chairman, A. P. A. Committee on Medical Practice, Boston, Mass.

Course will be given at Jung Hotel, 1500 Canal Street, New Orleans, La. Hotel reservations to be made directly with the Jung or hotel of your choice. Registrants who would like to enjoy Mardi Gras (March 2) are urged to make hotel reservations IMMEDIATELY.

Guest speaker for the luncheon on March 4 will be George Burch, M. D., Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cost of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-hour cocktail party with George Lewis and his band from Preservation Hall entertaining.

AMONG TOPICS TO BE DISCUSSED

"Detection of Incipient Psychiatric Disorders During a General Medical Examination"

"Medical Practitioners and Supportive Handling of Schizophrenia"

"Adolescence—Disturbed and Disturbing"

"The Physician and His Reaction to the 'Crock' "

"Newer Thoughts About the Therapy of Alcoholism"

"Medical Conditions with Psychiatric Manifestations"

"Recognition and Treatment of Depressive Reactions by Medical Practitioners"

"Treatment of Emotional States by the Medical Practitioner"

GENE L. USDIN, M. D., Chief
Division of Neurology & Psychiatry
Touro Infirmary
3516 Pryntania Street
New Orleans, La. 70115

Enclosed is my registration fee of $20 for the "Psychiatry for the Medical Practitioner" course to be given March 4-6, 1965, at the Jung Hotel. (Checks should be made payable to the Touro Infirmary.)

Name_____

Address_____

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Ophthalmology:
W. F. Park, M. D.
G. J. Pentecost, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Nancy Fondriest, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Manager:
Lester L. Cline

Obituaries

REUBEN RICHARD LOUFT, M. D.

Dr. Reuben Richard Louft, 58, of Charleston, died on November 14 at a hospital in that city after a brief illness.

He was a native of Washington, D. C., and was graduated from the University of Maryland. He received his M. D. degree in 1932 from the University of Maryland School of Medicine.

Doctor Louft served an internship and residency at the University Hospital in Baltimore, 1933-34, and was licensed to practice in West Virginia in 1935.

He was a member of the Kanawha Medical Society, West Virginia State Medical and American Medical Association.

Besides his widow, he is survived by four daughters, Mrs. Nancy L. Thompson of Springfield, Virginia; Gretchen Ann Louft of San Diego, California; Susan Clark Louft of Washington, D. C., and Jean Alden Louft of Charleston.

* * * *

CHARLES G. MERRIAM, M. D.

Dr. Charles G. Merriam, 79, of Page, Fayette County, died on November 25 in an Oak Hill hospital after an extended illness.

Doctor Merriam was born on March 1, 1885, in Marlboro, New Hampshire. He was graduated from Yale University and received his M. D. degree in 1911 from the Johns Hopkins University School of Medicine.

He was licensed to practice that same year in West Virginia and practiced in Stotesbury, Raleigh County, and other communities in that area before moving to Page twenty-four years ago.

Doctor Merriam was an honorary member of the Fayette County Medical Society, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by three sons, Allen Merriam of Corpus Christi, Texas, Rieman Merriam of St. Petersburg, Florida, and Charles S. Merriam of Panama City, Florida; and a daughter Mrs. Barbara Wilson of Barberton, Ohio.

* * * *

LEO HOWARD MYNES, M. D.

Dr. Leo Howard Mynes, 66, of Charleston, died on December 4 in that city.

Doctor Mynes, who served as chairman of the Committee on School Health of the West Virginia State Medical Association, was a native of Hurricane, Putnam County. He received his M. D. degree in 1924 from the University of Pennsylvania School of Medicine.

He became Medical Director for the Kanawha County School System in 1933 and served in that capacity until his death. He was a former member of the Charleston

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RICHARD L. BAUMGARTNER, M.D.

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KENNETH S. CROFOOT, Ed.D.
Clinical Psychologists

MARY JANE McCONAUGHEY, M.S.W.
JUDITH L. VERES, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

ESTHER L. SIMPSON, R.N.
Director of Nurses

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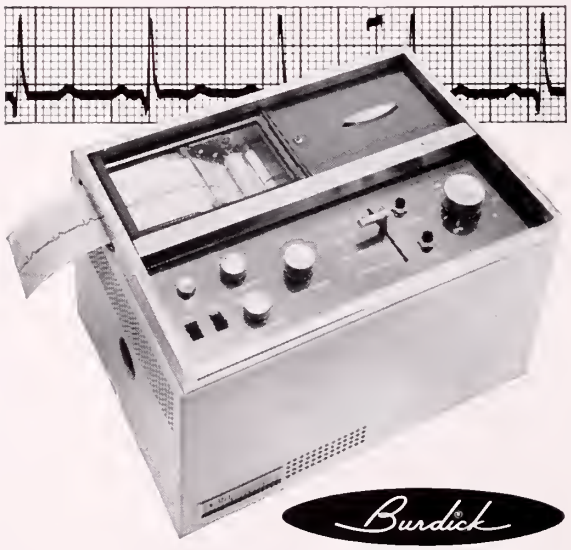

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city council and a past president of the West Virginia Tuberculosis and Health Association.

Doctor Mynes was a member of the Kanawha Medical Society, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a son, Charles L. Mynes of Charleston; and a daughter, Mrs. Ruth Dennie of St. Albans.

* * * *

JOSEPH BELL PALMER, M. D.

Dr. Joseph Bell Palmer, 85, of Wellsburg, died on November 1 in a Wheeling hospital.

He was born in Brooke County, July 15, 1879, the son of John Campbell and Frances Waugh Palmer, and attended public schools in Wellsburg.

He attended Longmont Academy in Longmont, Colorado, and the University of Michigan in Ann Arbor, Michigan, and received his M. D. degree in 1905 from Jefferson Medical College in Philadelphia. He was licensed to practice in West Virginia the following year after serving an internship in a New York City hospital.

Doctor Palmer was an honorary life member of the Brooke County Medical Society, West Virginia State Medical Association and the American Medical Association.

He is survived by one sister, Miss Sara Palmer of Wellsburg, and a nephew, Dr. David W. Palmer of Wheeling.

* * * *

RICHARD CAMDEN STARCHER, M. D.

Dr. Richard Camden Starcher, 57, of Ripley, died on November 22 in a Charleston hospital following a long illness.

Doctor Starcher was a native of Ripley and was graduated from West Virginia University. He received his M. D. degree in 1935 from Jefferson Medical College in Philadelphia. He served an internship and residency at Western Pennsylvania Hospital in Pittsburgh, 1936-37.

He was a member of the Kanawha Medical Society, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by three daughters, Miss Margaret Lynn Starcher of Wilmington, Delaware; Miss Emily Ann Starcher of Ripley; and Miss Mary Camden Starcher, a student at West Virginia Wesleyan College in Buckhannon; and one sister, Miss Genevieve Starcher of Ripley.

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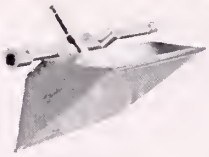

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. A. C. Edmundowicz of Morgantown was the guest speaker at a meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the Elks Country Club in Elkins on November 19.

Doctor Edmundowicz presented a paper on "Present Day Management of Cardiac Arrhythmias." He discussed the physiology of the conduction mechanism of the heart, atrial fibrillation, atrial flutter, paroxysmal tachycardia and ventricular fibrillation.

Dr. Charles L. Leonard of Elkins, a member of the Council of the West Virginia State Medical Association, reported on the most recent meeting held in Charleston on November 8.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Forty-three members and guests attended the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on November 12.

Dr. Peyton E. Weary of Charlottesville, Virginia, was the guest speaker. A member of the Department of Dermatology at the University of Virginia School of Medicine, Doctor Weary presented an interesting and comprehensive paper on "Gardner's Syndrome" and on "Pigmentary Disorders of the Skin."

The Society unanimously approved the application of Dr. George M. Lyon for honorary life membership. Doctor Lyon will retire on February 28 as Director and Chief of Staff of the Huntington VA Hospital.—W. L. Neal, M. D., Secretary.

* * * *

HARRISON

Dr. Sherman E. Hatfield of Charleston was the guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on November 5.

Doctor Hatfield presented an interesting paper on "Acute Diseases of the Ear: Diagnosis and Treatment."

Doctor A. R. Marks, the president, presided at the business meeting.

* * * *

MERCER

The Mercer County Medical Society held its regular monthly meeting at the West Virginian Hotel in Bluefield on October 19.

The guest speakers were Mr. Robert Harrah of Charleston and Mr. Claire Boso of Lewisburg, who presented an interesting program on venereal disease. Mr. Harrah is a Public Health Advisor for the USPHS Bureau of Venereal Disease and Mr. Boso is a Disease Investigator for the same agency.

The Society unanimously approved a motion changing its annual election of officers from the December to the November meeting beginning in 1965.

Dr. Theodore S. Raiford of Asheville, North Carolina, president of the Medical Society of the State of North Carolina, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on November 16.

Doctor Raiford presented a most interesting talk on the "Proper Use and Abuse of Medical Facilities."

Dr. Sam Milchin was elected president for the coming year succeeding Dr. John J. Mahood. Dr. Weldon M. Harloe was named vice president and Doctor Mahood secretary-treasurer.—J. Brookins Taylor, M.D., Secretary.

* * * *

RALEIGH

Dr. Warren D. Elliott was elected president of the Raleigh County Medical Society at its regular meeting which was held at the El Chico Restaurant in Beckley on November 19. He succeeds Dr. B. B. Richmond.

Dr. Richard G. Starr was named president elect at the annual dinner meeting and Dr. Worthy W. McKinney secretary-treasurer.

Dr. William Sewell, Associate Chief of Surgery at the Oteen, North Carolina Veterans Hospital, was the guest speaker. Doctor Sewell has done 12 years of research on coronary artery disease.

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Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

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G. E. HARTLE, M. D.

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E. L. GAGE, M. D.
WM. F. HILLIER, M. D.

Urology:
T. B. BAER, M. D.

Eye, Ear, Nose & Throat:
F. D. WHITE, M. D.
A. J. PAINE, M. D.

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CARL C. BARGER, M. D.
GRADY McRAE, M. D.

OBSTETRICS & GYNECOLOGY
E. W. McCAULEY, M. D.
C. G. THEDIECK, M. D.
JOHN H. SPROLES, M. D.
CHARLES S. FLYNN, M. D.

INTERNAL MEDICINE
J. R. SHANKLIN, M. D.
KARL E. WEIER, M. D.
H. F. WARDEN, JR., M. D.
C. D. PRUETT, M. D.
R. O. ROGERS, JR., M. D.

PATHOLOGY
DAVID F. BELL, JR., M. D.
JOHN J. BRYAN, M. D.

ROENTGENOLOGY
S. G. DAVIDSON, M. D.

ANESTHESIOLOGY
DAVID H. GATHERUM, M. D.

AUDIOLOGY AND SPEECH PATHOLOGY
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Second Vice President: Mrs. C. J. Holley, Wheeling
Third Vice President: Mrs. J. A. B. Holt, Charleston
Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William R. Rice, Dunbar.

GREENBRIER

The Woman's Auxiliary to the Greenbrier Valley Medical Society held its regular monthly meeting at the Oak Terrace Hotel in Lewisburg on November 17.

Miss Margaret Arbuckle, Greenbrier County Health Nurse, was the guest speaker. She discussed the facilities now available at the newly-built County Health Center.

* * * *

HANCOCK

Mrs. Richard A. Rose was the hostess at a luncheon meeting of the Woman's Auxiliary to the Hancock County Medical Society which was held at the Williams Country Club in Weirton on November 17.

Mrs. Leonard E. Yurko, the president, presided at the business meeting and Mrs. Edward A. Gretchen presented the secretary's report.

Mrs. E. M. Clubb, Jr., reported on the city's mental health project and Mrs. Myer Bogarad on the Children's Home birthday program.

* * * *

HARRISON

Members and guests of the Woman's Auxiliary to the Harrison County Medical Society were entertained with a fashion show at their regular monthly meeting which was held at the Stonewall Jackson Hotel in Clarksburg on December 3.

Many of America's noted designers were represented in the latest group of holiday, cruise and early spring fashions.

Mrs. L. Dale Simmons, Legislative Chairman for the Woman's Auxiliary to the West Virginia State Medical Association, introduced the guest speaker, Mrs. Jeanne S. Holt.

Mrs. Holt, president of the Classroom Teachers Association, presented a film prepared by the West Virginia Education Association on the needs of the State's schools.

Mrs. J. D. H. Wilson, the president, presided at the business meeting and Mrs. Albin A. Galuszka served as program chairman.—Mrs. Karl A. Dillinger, Press and Publicity.

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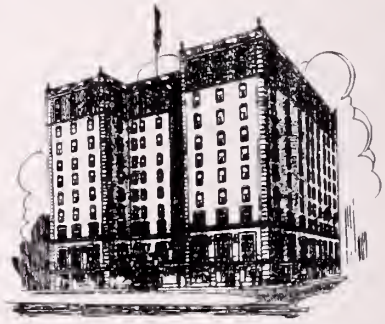

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KANAWHA

Mrs. A. C. Chandler shared her experiences aboard the S. S. Hope with 63 members and 12 guests at the November meeting of the Woman's Auxiliary to the Kanawha Medical Society.

Doctor and Mrs. Chandler traveled last year to Ecuador aboard the 15,000 ton ship which takes to other countries the best America has to offer in the fields of medicine, dentistry and paramedicine.

Mrs. Chandler explained that the ship's name stands for its mission: "Health Opportunity for People Everywhere." During its stay in Ecuador, more than one million inoculations were given in addition to major surgery, treatment of injuries and disease, care and diet of infants and sanitation.—Mrs. Arthur A. Abplanalp, Publicity Chairman.

* * * *

McDOWELL

Mrs. J. A. B. Holt of Charleston was the guest of honor at the annual luncheon of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. Dante Castrodale in Welch on November 12.

Mrs. Holt, third vice president of the Woman's Auxiliary to the West Virginia State Medical Association, discussed briefly the Auxiliary's fund raising project for the hospital ship S. S. Hope.

Mrs. J. Hunter Smith, the president, presided at the business meeting. Hostesses were Mrs. Castrodale and Mesdames Richard O. Gale and Charles B. Chapman.

* * * *

MERCER

The Woman's Auxiliary to the Mercer County Medical Society held a joint meeting with the Dental Auxiliary in November at the Y Center in Bluefield.

The guest speaker was Dr. James Bailey, a veterinarian from nearby Green Valley, Virginia. He related, in a humorous vein, his experiences as a practicing veterinarian.

Mrs. Joe E. McCary, the president, presided at the business meeting. Final plans were made for the distribution of Christmas gifts to the patients at Pinecrest Sanitarium in Beckley.

* * * *

MINGO

Plans for the annual Christmas Party were discussed at a meeting of the Woman's Auxiliary to the Mingo County Medical Society at the Mountaineer Hotel in Williamson on November 19.

Mrs. W. H. Price and Mrs. W. J. Smith were hostesses for the luncheon meeting. Mrs. Andrew H. Henderson, the president, presided at the business meeting.

The annual Christmas Dinner and Party was held at the Mountaineer Hotel on December 9.

* * * *

MONONGALIA

The Woman's Auxiliary to the Monongalia County Medical Society entertained the Caduceanns at an informal reception at the Morgantown Country Club on November 3. The Auxiliary sponsors the organization which is composed of the wives of students at the West Virginia University School of Medicine.

Mrs. Arthur W. Kelley, the president, welcomed the guests and introduced Mrs. Clare D. Edman, president of the Caduceanns, who responded.

Mrs. Robert Greco was in charge of the program which included a style show.

Mrs. Herbert N. Shanes of Grafton, First Vice President of the Woman's Auxiliary to the West Virginia State Medical Association, was a guest at a meeting of the Woman's Auxiliary to the Monongalia County Medical Society at the Hotel Morgan on December 1.

Mrs. Byron M. Bloor was the hostess for the dinner meeting and was assisted by Mesdames D. Franklin Milam, French R. Miller, Charles S. Mahan, Hubert T. Marshall, John L. Lawless and Allen E. Yeakel.

Mrs. Arthur W. Kelley, the president, presided at the business meeting. Members contributed funds for Christmas gifts for the children at St. Marys Training School.—Mrs. Hubert A. Shaffer, Corresponding Secretary.

* * * *

POTOMAC VALLEY

Mrs. George A. Curry of Morgantown was the guest speaker at the November meeting of the Woman's Auxiliary to the Potomac Valley Medical Society which was held in Keyser.

Mrs. Curry, president of the Woman's Auxiliary to the West Virginia State Medical Association, urged members to broaden the scope of their work through the projects of the Auxiliary's International Health Activities.

She discussed briefly "Project HOPE" and its mission with the utilization of the hospital ship S. S. Hope. She said that the State Auxiliary has an organizational membership and that county auxiliaries are being urged to secure similar memberships.

* * * *

RALEIGH

"The One Who Heals," a color film produced by the American Medical Association's Department of Medicine and Religion, was shown at the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society at the Beckley Hotel on November 16.

The film showed the importance of physician-clergy relationship in the treatment of patient and parishioner. Mrs. John E. McKenzie said the need for this relationship has long been recognized and that the AMA has now created the climate for communication between the two professions.

Mrs. Charles W. Merritt, the president, presided at the business session and introduced wives of clergy and other guests.—Mrs. John E. McKenzie, Press and Publicity.

Books Received

AETIOLOGY OF DIABETES MELLITUS AND ITS COMPLICATIONS—By Margaret P. Cameron, M. A. and Maeve O'Connor, B. A. Little, Brown and Company, Boston, 1964. Pp. 405. Illustrated. Price $12.50.

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WANTED—Opening available on July 1, 1965, for general practitioner in Green Bank, W. Va., site of the National Radio Astronomy Observatory. Fully equipped medical office in a scientific environment. Contact Mr. J. R. Plunkett, Administrative Service Officer, Green Bank, W. Va. Phone 456-2011.

GENERAL PRACTITIONER—Urgent need and excellent opportunity for general practitioner. Solo practice or association with established young GP in Berkeley Springs, W. Va. A clean, progressive, small town within easy driving distance of Washington, Baltimore and Winchester. 60-bed modern hospital. Office space, housing and financial help available. Above average income. Contact C. A. Burgess, M. D., 1090 Fairfax Street, or Robert L. Hale, War Memorial Hospital, Berkeley Springs, W. Va.

WANTED—General practitioner for small community and large surrounding farming area—near coal mines. Good roads and modern conveniences. Retired physician with fifty years experience in general practice and the citizens are interested in helping a physician and believe that the locality offers many advantages. Contact Dr. A. O. Kelly, Wallace, W. Va. Phone 796-3910.

HOUSE PHYSICIANS WANTED—Two openings in a general hospital with 150 beds. Salary open, commensurate with qualifications of applicant. Interview desired and will reimburse one-way fare for same. Write DOD, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324

PHYSICIAN WANTED — An experienced general practitioner to add to and work with an established salaried group in metropolitan area. This provides regular hours and minimal night work. Contact Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302.

WANTED—Physicians needed to take over established practice of deceased physician. Modern office available in community located in Southern West Virginia. Trading population of 75,000. Splendid opportunity for one or more physicians. Contact BLW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

GENERAL SURGEON—Additional general surgeon needed. F.A.C.S. preferred. Rural community with excellent hospital facilities. Write BBB, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

ANESTHESIOLOGIST — Seeking new location in small community. Training received at well-known New England clinic. Ten years experience with large city group. Write POK, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

HOUSE PHYSICIAN WANTED—Opening in a new 42-bed hospital. Salary open and good working conditions. Write CCC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

FOR SALE—X-ray and Fluoroscope in good working condition. Write LLL, West Virginia Medical Journal, Box 1031, Charleston, W. Va.

WANTED—General practitioner for modern 40-bed accredited hospital. Chief of Staff will offer office space and/or partnership to a qualified and ambitious physician. Growing industrial community of 2500 citizens, with a drawing area of approximately 10,000. Located in the beautiful South Branch of the Potomac—the heartland of West Virginia's recreational area. Write Mr. Robert G. Via, Administrator, Hampshire Memorial Hospital, Romney, W. Va.; or phone collect 737.

AVAILABLE—Anesthesiologist desires to locate in West Virginia upon completion of training in June, 1965. Nine years experience in general practice. Foreign graduate and licensed in West Virginia. Write LAC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Full-time director for emergency room of 300-bed hospital. Duties to include supervision of the emergency room activities of the house staff—currently numbering 26 interns and residents. Must be eligible for licensure; salary open. Contact D. Hamaty, M. D., Director of Medical Education, Memorial Hospital, 3200 Noyes Avenue, S. E., Charleston, West Virginia.

WANTED—General practitioner for large, modern coal mines in southern West Virginia. A splendid opportunity for an energetic practitioner. Write GAC, The West Virginia Medical Journal, Box 1031, Charleston 24.

PHYSICIAN WANTED—Physician trained in obstetrics or with special interest in obstetrics to do mostly obstetrics and some general practice in association with qualified man in group. Excellent guarantee and a good future. Write NNN, The West Virginia Medical Journal, Box 1031, Charleston, W. Va.

WANTED—General practitioner in Richwood. Citizens of this community are interested in helping physician and believe that the locality can offer an ambitious doctor many advantages. Contact Sr. M. Pia. C.M.P., Administrator, Sacred Heart Hospital, Richwood, W. Va.

INTERNIST NEEDED — Services of an internist needed in fast growing community. Excellent hospital facilities and office space available. Write TMB, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Physician for staff position in medical department of Union Carbide Corporation Chemical Plant with approximately 4,000 employees. Liberal benefits; salary commensurate with experience and qualifications; State license required; age limit 65. Write to E. Q. Hull, M. D., Medical Director, Post Office Box 8004, South Charleston, W. Va. 25303.

WANTED—Two general practitioners to locate in the vicinity of Hundred, W. Va., which includes a large area and good advantages. Write Mrs. Mary Mike, Route 1, Burton, W. Va.

WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031, Charleston W. Va. 25324.

PEDIATRICIAN—31 years old, married, board eligible, and seeking location. Will be released from active military service in approximately 60 days. Interested in associate or group practice. Write CSC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

The West Virginia Medical Journal

February, 1965 Vol. 61, No. 2

Pneumocystis Carinii Pneumonia With Hypogammaglobulinemia

(Case Report)

Thomas Dotson, M. D., and Andrew J. Kapcar, Jr., M. D.

The purpose of this paper is to report a case of fatal interstitial plasma cell pneumonia caused by pneumocystis carinii. The entity, common in Europe, has been reported only a few times in the United States and to our knowledge has not been reported in West Virginia.

Clinical History

The patient, an 8-month-old white girl, was admitted on February 8, 1964, being transferred from Beckley Memorial Hospital, with the chief complaint of respiratory distress. Gestation and delivery had been normal. Birth weight was 6 pounds, 7½ ounces.

She had been followed in the Beckley Memorial Hospital Clinic from November 27, 1963 to December 30, 1963 for complaints of cough and hoarseness that responded somewhat to expectorants and antibiotics but did not clear. Outpatient studies included a barium swallow that was negative and a blood count that revealed 20,900 WBC, with 14 per cent eosinophils and 67 per cent lymphocytes.

She was admitted to Beckley Memorial Hospital on February 1, 1964, with a dry, frequent cough, cyanosis of the lips and nail beds, and moderate respiratory distress. Aside from this, the physical examination at that time was reported within normal limits. A chest x-ray showed accentuation of the markings of the lung fields. The heart was of normal size and configuration. Repeat barium swallow was negative. ECG was normal. CBC showed hemoglobin 12.6 Gm., hematocrit 41 vol. per cent, white blood cells 16,500, with 5 per cent eosinophils, 58 per cent neutrophils, 6 per cent stabs, 30 per cent lymphocytes and 1 per cent monocytes. Urinalysis was normal. The stools were negative for ova and parasites. She was febrile during the first two days. Therapy consisted of a croupette with oxygen and mist, antibiotic, expectorant, and antipyretic. On admission, the cyanosis responded well to oxygen. At this point she was transferred to Charleston Memorial Hospital.

Family history revealed that her parents are living and well and two brothers, ages 23 and 19, are in good health. Four siblings died at ages 4 months, 5 months, 7½ months and 3 months, with diagnoses of diphtheria, congenital heart disease, chronic respiratory trouble and "collapsed windpipe." Only in the case of the last sibling was an autopsy performed. There was no family history of cystic fibrosis. Review of systems was noncontributory.

On admission to this hospital, physical examination disclosed a well developed, 15-pound white female with marked respiratory distress. Temperature 104 F., heart rate 170 per minute, respirations 110 per minute.

Examination of the eyes, ears, nose and throat was within normal limits. The neck was supple. There was no palpable lymphadenopathy. The

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Submitted to the publication Committee, June 24, 1964.

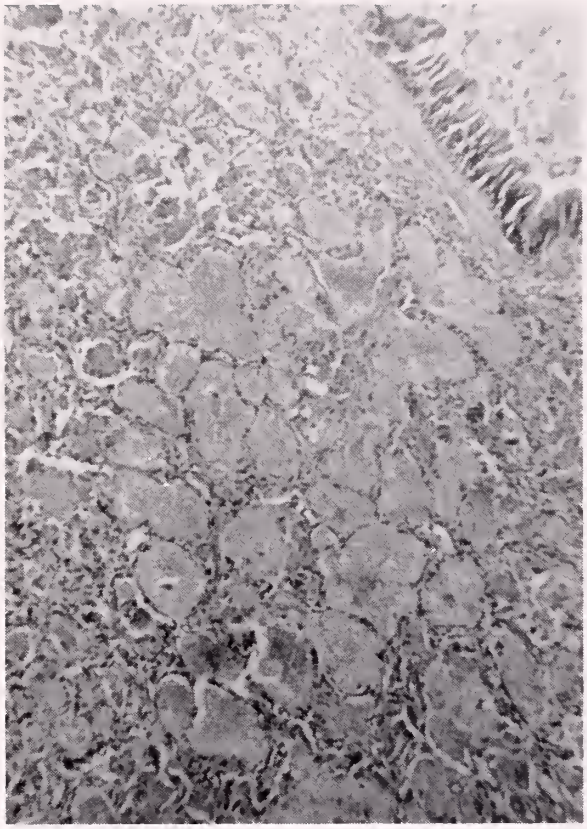

Figure 1. Lung, H and E (100x). Honeycomb appearance of alveolar spaces adjacent to terminal bronchiole.

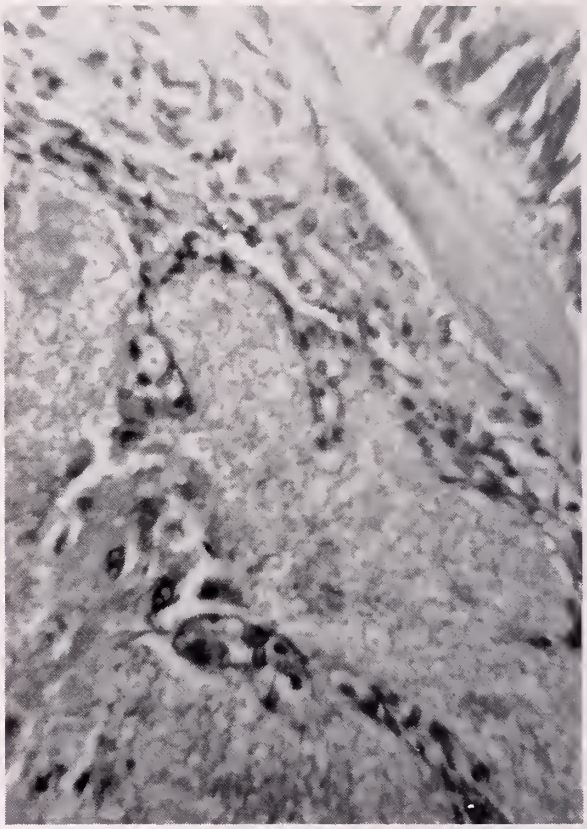

Figure 2. Lung, H and E (430x). "Foam formation" of Vanek in Pneumocystis carinii pneumonia.

thyroid gland was not enlarged. Chest disclosed minimal retractions and marked tachypnea. The lungs were clear to percussion and auscultation. No wheezes, rhonchi, rales, nor dullness could be elicited. There was generalized cyanosis that responded slightly to oxygen therapy. The peripheral pulses were intact. There was no clubbing of the digits. Abdominal examination showed no tenderness, guarding, nor rigidity. The abdomen was flat; the liver was palpated 2 cm. below the right costal margin and was soft in consistency. Neither the spleen nor the kidneys were palpated. No masses were felt. Bowel sounds were physiologic. There was an erythematous perianal rash; the back and spine were not remarkable. Genitalia were those of a normal prepubertal female. Extremities were symmetrically normal. Neurological examination was intact.

Blood count on admission showed hemoglobin 13.5 Gm., hematocrit 41 vol. per cent, WBC 22,990, with 64 per cent segmented neutrophils, 1 per cent stabs, 30 per cent lymphocytes and 5 per cent monocytes. Red blood cells were essentially normal in appearance as were the platelets. Urinalysis was normal. Throat culture grew Staphylococcus, coagulase negative, and alpha hemolytic streptococcus. Stool examination was negative for ova and parasites. Gamma globulins were reported as 0.5 Gm. per cent. Total proteins were 6.2 Gm. per cent with 3.1 Gm. per cent albumin and 3.1 Gm. per cent globulin. Palm test was negative. Chest x-ray disclosed increased peribronchial tracing within normal limits for a juvenile pattern.

On admission she was placed in a croupette with water mist and oxygen and digitalized with elixir of digoxin. Respirations continued rapid, and coughing was frequent. On February 9, she continued to be cyanotic about the lips and nail beds. Coughing continued, but was not productive. She retained small amounts of milk and showed little sign of improvement. By February 11, the respiratory rate was 80 per minute and the pulse 160 per minute.

Scratch test and intradermal milk sensitivity tests were negative. Tracheal aspirations and smear of the secretions with silver stain were not revealing. On February 12, the infant was out of oxygen for five minutes. The heart rate dropped to 70 per minute and respirations dropped to 100 per minute. Approximately one hour later, the pulse and respirations stopped. Mouth-to-mouth resuscitation was started. The trachea was suctioned and milk was removed. External

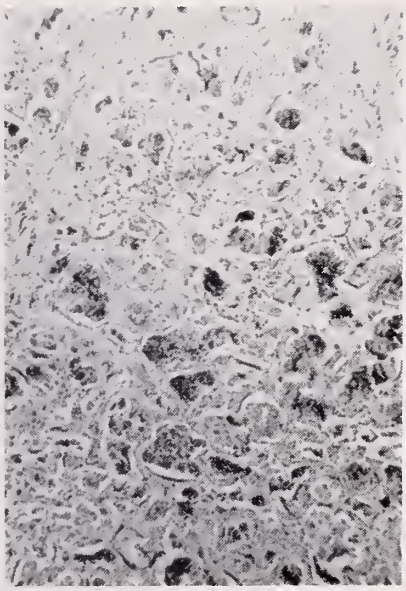

Figure 3

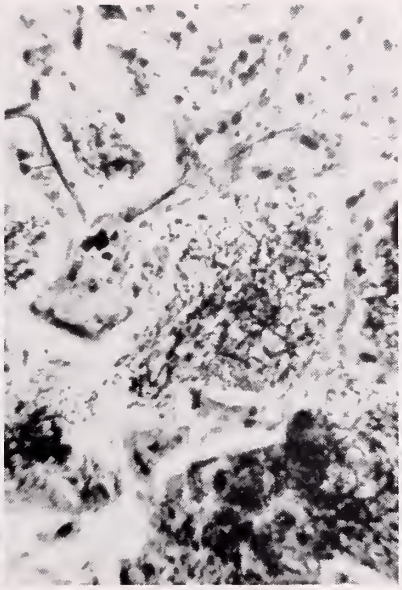

Figure 4

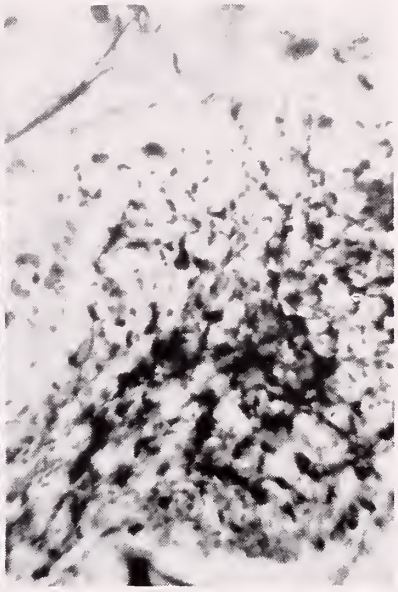

Figure 5

Figure 3. Lung, Gomori's methenamine silver (100x). Characteristic exudate in Pneumocystis carinii pneumonia. Figure 4. Lung, Gomori's methenamine silver (430x). Pneumocystis carinii pneumonia. Figure 5. Lung, Gomori's methenamine silver (970x). Pneumocystis carinii pneumonia.

cardiac massage and endotracheal oxygen temporarily restored the cardiac rhythm, but it could not be sustained.

Gross Pathology

By request the internal examination was confined to the thoracic cavity. Each lung was pale yellow to tan to pink on external surface. Neither lung floated in formalin. The consistency of each lung was uniformly firmer than normal, and no crepitations were present. The cut surfaces were gray-tan to pink, and disclosed focal areas of hemorrhage. The consistency was moderately firm throughout each lung.

Histopathology

H. and E. sections disclosed a uniform and extensive replacement of the alveolar spaces by an eosinophilic staining material which had a "foamy" pattern. Discrete hematoxylinophilic bodies were noted, surrounded by circular clear zones suggesting in some fields, a microcystic pattern. PAS stains disclosed occasional positively stained hyalin-like material within the exudate. Gomori's methenamine silver stains disclosed an argyrophilic stained network previously described in the literature. The morphological pattern was that of pneumocystis carinii, as described by others. The alveolar septa showed a mononuclear cellular infiltrate consisting predominantly of monocytes and lymphocytes, and an occasional plasma cell.

Discussion of Pathologic Findings

The gross appearance of the lungs in this disease has shown little variation judging from its description in the literature. The uniform grey, firm consistency is characteristic. The histologic pattern is even more unique. The eosinophilic, honeycombed exudate (or "foam formation" as it has been called by Vanek) within the alveolar spaces is best demonstrated with Gomori's methenamine silver stain. In matching ribbons, so to speak, with photomicrographs of previously reported cases in the literature, the differential offers little problem. No coexisting cytomegalic inclusion bodies were demonstrated in the lung sections in this case as has been reported previously in similar cases. In contrast to reported European experience, the interstitial infiltrate in our case is predominantly monocytic and histiocytic with only an occasional plasma cell noted. The latter finding further corroborates the observation of Burke, Krovetz and Good[1] noting the poor plasma cell response in instances of pneumocystis carinii pneumonia associated with hypogammaglobulinemia.

General Discussion

Interstitial plasma cell pneumonia is an unusual type of infantile pneumonitis prevalent in Central Europe, particularly in Germany, Austria, Czechoslovakia, Switzerland, and the Scandinavian countries. In recent years, cases have been reported from other parts of the world, namely, South America, Africa, Australia, Canada and the United States.

Since Lunseth et al.[5] in 1955, reported the first case described in the United States, in Milwaukee, fatal cases have been reported in Connecti-

cut, Georgia, Louisiana, Texas, Oklahoma, Arizona, Illinois, California and North Carolina.[3]

Pneumocystis carinii, etiologic agent of interstitial plasma cell pneumonia, is considered by most investigators to be a protozoan parasite, though a few believe it to be a fungus.[4] It has not been propagated on culture media and cannot be transferred in laboratory animals. This favors the theory that it is a parasite.

Pneumocystis carinii was first demonstrated in the lungs of small mammals and in a man dying of trypanosomiasis in Brazil (Chagas, 1911). It subsequently was found in the lungs of humans and rodents in Europe and sporadically in rabbits, rats, cats, guinea pigs, dogs, sheep and goats. Vanek, in 1951, first associated the organism with the disease, although knowledge of interstitial plasma cell pneumonia in Europe dates chiefly from the descriptions of Ammich in Berlin and Beneke in Rostock, in 1938.[2]

Our case demonstrates many of the characteristic clinical findings that include progressive respiratory distress (dyspnea, tachypnea of 100-120 respirations per minute, sternal retractions), increasing cyanosis with improvement in oxygen, few abnormal findings on examination of the chest, nonproductive cough, leukocyte count normal or slightly elevated with slight neutrophilia or slight to marked eosinophilia, or both, progressive pulmonary infiltration on chest x-ray but not marked as in other infantile pneumonias, and no response to antibiotics, gamma globulin or cardiac drugs. [1, 2]

The disease occurs chiefly in premature and debilitated infants. The usual age group is five weeks to seven months with the peak morbidity in the third and fourth months. Childhood cases usually are associated with leukemia, lymphoma, Hodgkins' disease, anemia, agammaglobulinemia, Wegener's granulomatosis, and cytomegalic inclusion disease.[3]

In two cases reported by Burke, the gamma globulin levels ranged from 0.1-0.4 Gm. per cent and in our case the gamma globulin was 0.5 Gm. These values are well below the normal 0.7-1.25 Gm. per cent. Cases also have been described in patients with hematologic disorders who have received steroids.[3]

Gajdusek[2] reports a mortality rate of 20-25 per cent similar to the work of Jirovec, Vanek, Hamperl, Ahvenaurei and others. Recurrences following recovery are rare. There is no specific therapy. Antibiotics, ACTH, cortisone, gamma globulin, roentgen therapy and anti protozoal agents have been tried without success. In a few instances antifungal agents have been reported successful. High concentrations of oxygen humidification, and good nursing care are essential.[2]

Summary

A case of progressive respiratory distress due to bilateral pneumonitis caused by pneumocystis carinii in an infant is reported, accompanied by pathological findings and clinical discussion.

References

1. Burke, B. A., Krovetz, L. J. & Good, R. A.: Occurrence of Pneumocystis Carinii Pneumonia in Children With Agammaglobulinemia, Pediatrics 28:196-205, 1961.
2. Gajdusek, D. C.: Pneumocystis Carinii—Etiologic Agent of Interstitial Plasma Cell Pneumonia of Premature and Young Infants, Pediatrics 19:543-565, 1957.
3. Huneycutt, H. C., Anderson, R. W. & Hendry, W. S.: Pneumocystis Carinii Pneumonia, Am. J. Clin. Path. 41:411-418, 1964.
4. Kramer, R. I., Crane, V. C. & Moore, H.: Interstitial Pneumonia Due to Pneumocystis Carinii, Cytomegalic Inclusion Disease and Hypogammaglobulinemia Occurring Simultaneously in an Infant. Case Report With Necropsy Findings, Pediatrics 29:816-827, 1962.
5. Lunseth, J. H., Kirmse, T. W., Prezyna, A. P. & Gerth, R. E.: Interstitial Plasma Cell Pneumonia, J. Pediat. 46:137-145, 1955.

A good scare is worth more to a man than good advice.

E. W. Howe.

Some Results of Enzymatic and Chromosomal Abnormalities*†

Earl H. Baxter, M. D.

IRREGULARITIES of chromosomal and enzymatic patterns offer one of the most fascinating subjects in modern medicine. More and more conditions are now being attributed to such defects. A recent pediatric report contained reference to four new inborn errors of metabolism and one chromosomal abnormality. Although it has been 60 years since Garrod showed that alkaptonuria was due to an enzyme defect, only 5 years have elapsed since chromosomal diffusing in mongolism was recognized. It was Garrod's concept that such diseases are due to an enzymatic block that governs a single metabolic step in the complete utilization of a nutrient material. Since it is likely that one gene controls one enzyme, most of these defects follow the mendelian law of inheritance.

Each species has a characteristic number of chromosomes, and in man this is 46, composed of 22 pairs of autosomes and two sex chromosomes, the XY in the male and XX in the female. Any excess of X chromosomes or absence of Y produces a female type. During maturation of the germ cells the chromosomes, and it is suspected that genes in the same manner, are reduced to one-half the original number with the fertilized cell receiving one-half of its components from each parent. In the case of the sex chromosomes, however, many recognized irregularities occur during maturation with such resulting abnormal combinations as XO, XXX, XXY, XXXY, et cetera. It is assumed that similar conditions may occur in the autosomes. Some of these may be disjointed with translocation or dislodgment of part of the autosome or even of genes to another autosome. When so considered the possible number of irregularities is astronomical. Many of these are incompatible with life, while others may produce defects which cause early death or abnormalities extending through a relatively long life.

Turner's and Klinefelter's Syndromes

Turner's syndrome is an example of an XO pattern. This is a miniature female, sometimes with moderately webbed neck, who is sexually sterile and has 45 chromosomes. Klinefelter's syndrome, occuring in one in 400 births, is an XXY individual who is really a female but resembles a male. They have 47 chromosomes, and are usually sterile. This condition may account for some cases of sterility in the so-called male.

Mongolism as Exemplar

Chromosomal trisomy, the presence of an extra member in a pair of autosomes, is best exemplified by mongolism with an extra in the 20-21 pair. Mongolism of this type is thus characterized by 47 chromosomes and occurs in one in 700 births. Another form of mongolism, however, has 46 chromosomes. This represents a translocation of the abnormal chromosome to and junction with one of another pair. The mother, in this instance, has 45 chromosomes and carries this translocation as a recessive trait, but is normal. Since this is a transmissible trait, it follows the laws of inheritance with the possibility of its occurring one in four. This is important in counseling families about the possible repetition of mongolism and can be determined by chromosomal studies of the mongoloid child and its mother.

Several other forms of irregularity of the autosomes have been recognized and described. These are characterized by abnormalities of various systems of the body—congenital heart disease, mental retardation, small stature, defects of bone and joint, deformed ears and abnormalities of the extremities. With improvement in diagnostic facilities, undoubtedly the numbers of such conditions will increase in the future.

Enzymatic Block

There are many enzymatic steps in any metabolic process before cellular storage or utilization of nutrient material. Some of the intermediate

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*Presented before the Eighth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 27, 1963.

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Submitted to the Publication Committee, August 25, 1964.

products exist momentarily with succeeding enzymes exerting their effect at once, or some of the intermediate products may accumulate sufficiently in the blood stream to be recognized and isolated. These aberrations may be asymptomatic without any consequence to the host as found in cases of primaquine-induced hemolytic anemia. Others are sufficiently severe to produce death of the fetus of the child at a young age, or to produce irreversible damage as lipid storage disease, certain forms of cretinism, Wilson's disease and phenylketonuria. Clinical signs and syndromes of enzymatic block may result from an accumulation of substrate material which in high concentrations become toxic. It is also possible that the end product of the metabolic process is necessary for proper nutrition or another mutant gene may produce a by-pass of the original defect thus producing another substance that may be toxic to specific cells. Remote effects of such a defect may occur as in the case of the enzyme tyrosinase which is necessary to convert phenylalanine into tyrosine and later on in the metabolic process again is responsible for the production of melanin from its precursor. Thus, partial albinism may occur in conjunction with phenylketonuria. The effect may be mild to moderate with troublesome problems that are not incompatible with long life and productivity. Such conditions as alkaptonuria, gout, and some of the storage diseases are in this category.

Inherited Metabolic Disorders

Some of the inherited metabolic disorders are sex-linked such as hemophilia which appears in males and is transmitted through the female. Others are sex-limited such as the apparent preponderance of gout in males. Most of the sex-linked inborn errors of metabolism are attached to the autosome. The only known related defects on the Y chromosome is hereditary elliptocytosis in conjunction with the Rh factor.

Some of these metabolic defects if recognized early enough in life may be treated satisfactorily so that the individual is not defective or there is no organic damage. This is true of such conditions as phenylketonuria, galactosemia, celiac disease, and the glutathione reaction. In some other conditions, relief may be obtained by removing the offending accumulating substance from the body such as the use of BAL in the treatment of Wilson's disease by the removal of some of the excess copper.

Retarded Children

Phenylketonuria accounts for about 1 per cent of inmates of institutions for the retarded. In one state institution 25 such patients have been hospitalized for an equivalent of 410 patient years at a total cost of $840,000. It is estimated that if one patient can be cured it will thus save the taxpayers over $100,000 in custodial care. These patients are all similar in appearance with blond, light hair, blue eyes and reduced activity. They are usually good children and at times are mistaken for cases of albinism. It occurs in about one in 40,000. It is due to a recessive gene enzyme which is necessary to convert phenylalanine to tyrosine.

This increased phenylalanine produces brain damage. A by-pass of this enzyme block produces an excess of phenylpyruvic and phenylacetic acids which are excreted in the urine and can be detected by the presence of a greenish color when 5 per cent ferric chloride is added. This test may be positive soon after birth but is dependable at 4-6 weeks of age; by this time, however, there may be brain damage. An increased blood level of phenylalanine can be detected in the first days of life. If there is one case in a family, the physician should suspect that succeeding siblings may have the same defect. Damaging defects may be prevented by a diet low in phenylalanine.

No diet, however, is of any value after brain damage has developed. As a prophylactic measure the urine of all babies should be examined at birth and at age one month to determine the presence of phenylpyruvic acid.

Galactosemia

Galactosemia, although rare, is a familial condition characterized by inability to metabolize galactose. This is due to the lack of the enzyme phosphor-galacto-uridy-transferase which converts galactose into glycogen. These patients are characterized by severe hepatomegalia, the appearance of cataracts, mental retardation, and death. Some of these defects are reversible; cataracts and mental retardation, however, are not in this category. There are varying degrees of this defect, some of which may be mild enough to be compatible with life. A man of 61 years was reported to have this defect, but was symptom free. These patients are treated satisfactorily by the elimination of all lactose from their food intake.

Hurler's Syndrome

In Hurler's syndrome of gargoylism, there is storage of an abnormal mucopolysaccaride in those structures developed from connective tissue such as cartilage, brain, cornea, and the outer tissues of the heart. These children have a grotesque appearance. One type of this condition is characterized by corneal and lenticular difficulties with severe mental retardation and a short life. Another type may be familial with

little or no mental involvement. There also has been recognized a recessive trait in some normal individuals characterized by an abnormality in the storage of the same mucopolysaccaride. "Snorter dwarfism" occurs in cattle with somewhat similar features and with the same enzyme defect.

Other Conditions

Fibrocystic disease of the pancreas is characterized by the increased viscosity of the secretions of all glands of the body. It is probably due to some hitherto undiscovered enzyme or to the absence of one already known. Although this condition is known to be familial, it is difficult to determine any hereditary tendency due to the relatively short life of the involved individuals most of whom die before the age of reproduction. It is presently recognized that varying degrees of this occur since increased sweat chlorides have been found in the chronic emphysema of adults.

Glycogen storage disease involves various organs as the liver, kidneys, heart, or muscle, but all are variants of the same difficulty. This is due to an absence of glucose-6-phosphatase which converts glucose-6-phosphate into glucose and phosphate. Unfortunately, no enzyme replacement is known to relieve this condition nor is any dietary treatment of any value.

Hemoglobinopathies occur in many forms as a result of the 15 or more variants of hemoglobin found in various peoples in the world. These can result in a multitude of irregularities. The best known is sickle cell anemia occurring more often in the Negro with a preponderance of hemoglobin S. Thalassemia is due to a preponderance of the fetal form of hemoglobin. These two conditions at times seem to appear in the same individual. It has been shown that there is very little difference between the types of hemoglobin with the exception of variations in amount or absence of such amino acids as glutamic, valine, leucine, and glycine, and the arrangement of these acids in the amino acid chains that go to make up the various peptides in the hemoglobin. Chromotography and electrophoresis are of value in detecting these irregularities of hemoglobin types.

In some individuals hemolytic anemia develops following ingestion of certain substances such as naphthalene, acetanilid, sulfonamides, and some aniline dyes. This defect is due to the absence of the enzyme glucose-6-phosphate-dehydrogenase which is responsible for the conversion of the amino acid gluthathione to a useable product in the red cell. It may also occur in the newborn period by the indiscriminate and excessive administration of vitamin K if the enzyme is absent.

Other conditions too numerous to mention are known to be associated with enzymatic defects such as familial diabetes, abnormal urinary excretory products such as fructosuria, maple sugar urine disease, cystinuria, cystinosis, and other types of renal tubular function. As further investigation of the structure and character of DNA and RNA and how genes are distributed along chromosomes takes place and their mechanics and manipulation are better understood, undoubtedly many more of so-called incurable diseases and conditions may become subject to control.

In conclusion, a few common conditions that result from irregularity either of chromosomes or genes have been mentioned, with emphasis on some of those that can be remedied if recognized early and vigorous treatment instituted. Although most of these conditions are unusual, nevertheless "the rarest of conditions is very common if it occurs in you."

Stolen Drugs at Bargain Prices

RECENTLY a major American pharmaceutical firm was successful in suing a former employee for selling secrets of research and production of an antibiotic to an Italian drug manufacturer—however, not until long after the Italian firm, whose research and development costs had thus been paid by the American competitor, had underbid the same firm in a large sale of this drug back to the United States government. Vigorous protests by many persons and organizations are now being made against purchases by our government of foreign drugs produced on the basis of formulae and methods stolen from ethical American manufacturers.—Rocky Mountain Medical Journal.

A School Conservation of Hearing Program*

J. M. Cole, M. D.

When it is realized that from 3 per cent to 5 per cent of school children have significant hearing impairment on entering school or at some time during their school years, the desirability of a school hearing program becomes apparent. Many, if not most states now have a hearing program in the public schools and the author certainly feels that this should be universal. There can be no doubt that there are many improvements to be made in many of the programs that constitute worthwhile undertakings for physicians, educators, legislators, and all interested parties in the two large fields of health and education. Audiologists, teachers of the deaf, speech therapists, psychologists, experts in rehabilitation, class room teachers and, most certainly, family physicians and parents are vitally interested in the hearing-handicapped child.

The ideal school conservation of hearing program should be designed to invariably make known to school officials, parents and their physicians, all those children who have significant hearing difficulties or medical ear conditions which might lead to hearing difficulties. After finding these children with hearing defects, the program should follow-up in their medical care to assure that appropriate treatment is obtained or special educational services instituted as is appropriate in the individual case. As a matter of fact, any program worthy of the name should be geared to meet the needs of hearing-handicapped children long before they enter public school. Obviously, the severely hearing-handicapped child never can avail himself of the opportunities of the hearing individual unless a special effort is made to develop speech and the whole complex of interpersonal communication in which hearing is such an important part. Indeed, any program which would aspire to the ideal should be geared to conserve hearing prior to the onset of any hearing defect and should include an educational program in prevention of hearing problems. There still are far too many children suffering from preventable handicapping hearing defects. These problems can be prevented with modern knowledge. Unfortunately, there still is not great enough awareness of the dangers of the chronic draining ear and the "one shot" treatment for acute otitis media. All physicians should avoid the use of neurotoxic drugs, if at all possible, specifically streptomycin, kanamycin and, especially, dihydrostreptomycin, unless these are urgently indicated and there is no substitute nontoxic drug available that will be as effective. Although erythroblastosis fetalis is not preventable, it is treatable and kernicterus can be reduced. Prenatal, natal and postnatal care to prevent trauma, drug injury, anoxia and birth injury should all be considered in a conservation of hearing program.[1]

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Screening Tests

The most obvious portion of a school conservation of hearing program is screening tests of school children. It has been well established that these can be of value in identifying children with hearing losses which interfere with education.[2] It has not been settled to anyone's satisfaction just how this might best be done. Usually compromises are made in allowing for less than ideal testing areas, frequency of tests, incompletely or partially trained audiologists or technicians and, unfortunately, hearing testing that is not combined with an otologic examination. Currently available audiometers are not always entirely satisfactory in their ability to remain in calibration. Normal hearing thresholds for children have been demonstrated to be appreciably better than the American standard. The definition of what is a tolerable sound environment for screening tests in school children is not well established. A great deal of work along these lines, however, has been done by Eagles[3] and his co-workers in studies in Pittsburgh and in a long-term study of the Subcommittee on Hearing in Children of the American Academy of Ophthalmology and

*Presented before the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at White Sulphur Springs, April 15-18, 1964.

Submitted to the Publication Committee, July 10, 1964.

Otolaryngology. These studies pointed out the desirability of conducting at least yearly tests in school children until the age of ten and the importance of coupling this with otologic examination, if significant ear pathology is not to be overlooked. This can be facilitated by asking parents to fill out a short pre-test questionnaire to alert those carrying out hearing tests to children having prior histories of earache or draining ears or conditions with which hearing loss is commonly associated.

In Pennsylvania for the past several years a program has been carried out in which, by law, school children have yearly screening tests from kindergarten through the third grade, in the seventh grade, or first year of Junior High School, and in the tenth grade, or first year of Senior High School. These tests ordinarily are carried out by school nurses with standard audiometers for frequencies of 250 through 6,000 at 15 decibels. If, on threshold retest within a month, two or more frequencies in either or both ears are missed at 15 decibels, or if one freqency is missed at 25 decibels, the parents are informed by the nurse that hearing difficulty is suspected and medical consultation is requested with a follow-up report to be sent to the school nurse. In cases in which family finances will not permit the follow-up, funds are available through the Pennsylvania State Department of Health for referral to otologists or clinics for otologic and audiologic evaluation and treatment when indicated. Currently, threshold audiograms are requested for all first grade pupils. It is too early to assess the value of this new effort to make threshold audiograms for all first grade students. Undoubtedly the program could be strengthened by providing better sound environments for testing purposes, assurance of better calibration of audiometers, and provision of better trained individuals to do the testing. Greater benefits would result if pre-test histories were obtained and if otologic evaluation could be made near or at the time of the screening testing. These are all difficult tasks to accomplish on a statewide basis but probably are attainable with an added investment of monies, more and better trained personnel, and better facilities for the program.

Adequate Follow-Up

It has seemed in the past that the weakest link in the program, however, has not been in the testing program itself but in follow-up, to assure that those children who are suspected of having significant hearing losses receive adequate medical attention and care and rehabilitation services when indicated. Fortunately, special educational facilities are becoming more available. Efforts to alert physicians to the necessity for full cooperation in the essentials of the school hearing conservation program have not been entirely successful. Apparently everyone agrees that although physicians are the most important link in the program, they are the most difficult to enlist for all-out support in the complex requirements for an ideal hearing conservation program.

Continued efforts in education of parents and their relatives in the portions of the program in which they must cooperate are extremely important. A good school conservation of hearing program itself, of course, helps to educate students who will be future parents in ways in which they can safeguard hearing. There are, in general, far too few otologists but all otologists can and should alert family physicians, pediatricians, obstetricians and other medical colleagues to the vital role which they play. All physicians who have occasion to examine and treat ears should be instructed in the importance of routine use of the pneumatic otoscope, especially in children, so that they will be equipped to recognize middle ear effusions or immobility of the tympanic membrane which so often accompanies the early stages of chronic or incipient chronic ear disease. Ideally, this educational process should start with the medical training of the young physician in medical school. Efficient and energetic departments of otolaryngology unfortunately are not always considered vital to the basic medical education. Until this need is recognized, extra efforts for passing on this essential information to those physicians who have the greatest opportunity in conservation of hearing, namely, the family physician and the pediatrician, must be an important duty of all otolaryngologists interested in conservation of hearing.

Summary

Conservation of hearing is admittedly a difficult task and requires full cooperation of many disciplines including those in medicine, audiology, education, teachers of the deaf, speech correctionists and, last but far from least, legislators and, most important of all, taxpayers. It seems to me at times that as Americans, as parents, as physicians and as taxpayers, we permit vast sums of community money to be spent for space and other somewhat "far out" research developments but we don't always insist that available knowledge and relatively more easily attainable goals be applied in the conservation of our most important resource, namely, the human resource. When we stop to think of it, hearing certainly is vital to human well being. With from 3 per cent to 5 per cent of our school children variously handicapped by hearing problems, conservation

of hearing would seem to be an appropriate form of endeavor. Indeed, hearing loss is generally conceded to be numerically the most frequent current physical disability encountered in our total population. It certainly is past the time when more vigorous efforts at prevention of hearing defects and early recognition of those which are not preventable, or have not been prevented, are needed. Effective treatment of treatable conditions should be carried out with promptness and effectiveness. When remedial treatment is not possible, then facilities for rehabilitation and special education must be made available to preserve or to develop useful and gainfully employed citizens of the future. Lack of adequate concern and effort can result only in lost opportunities to prevent and to mitigate hearing and communication disabilities.

References

1. Taylor, G. D.: The Problem of Congenital Deafness, South. M. J. 57:1-8, 1964.
2. Siegenthaler, B. M. & Sommers, R. K.: Abbreviated Sweep-Check Procedure for School Hearing Testing, J. Speech and Hearing Disorders 24:249-257, 1959.
3. Eagles, E. L., et al: Hearing Sensitivity and Related Factors in Children, The Laryngoscope (Special Supplement), (June) 1963.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, perferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Special Article

The Role of the General Practitioner*

W. Edward Duling, M. D.

To describe the role of the general practitioner would be synonymous with saying anyone who practices medicine. It has been nigh impossible to find an adequate definition in dictionaries, journals or textbooks. So, from my own experience, I would define the term as any physician who limits his practice to sick people. The other morning on the Breakfast Club, I heard Don McNeil define a specialist as the doctor who can make a patient cough up twenty-five dollars after the latter had swallowed a nickel.

Historically, the general practitioner was "the" doctor until World War II. He cured everything, operated on anyone, delivered babies and reduced fractures. This role, however, seemed to hit low ebb during the immediate post-war years and the lull lasted until somewhere in the mid 1950's. The low ebb seemed to have been caused by the rapid strides that medicine took during the war years, e. g., in the specialty of psychiatry, a field that was almost revolutionized by the war and one that has since continued to make rapid progress. Also, the accelerated medical education program that developed during the war turned out younger physicians who seemed more inclined to limit their practice. Another factor was that while this was taking place older physicians who had been in general practice began limiting their practice to fields of special interest. Still another factor that has greatly influenced the decrease in interest in general practice is the attitude that the medical schools apparently have adopted and instilled in the minds of the students. This is rather an incidental factor in that the courses are taught only by teachers of various specialties. I do not say this derogatorily because in the final outcome students are graduated with a far better understanding of the subject material than would have been the case had they been instructed by teachers with a general knowledge of medicine.

As I said previously, the field of general practice includes a portion of all branches of medicine but is centered primarily around general medicine. The latitude of the field is the one fundamental aspect responsible for its peculiar interest —a smattering of obstetrics, geriatrics, dermatology, orthopedics and pediatrics, all in a day's practice or routine. There must be something to the phrase, "Variety is the Spice of Life," because we find that variety in medicine undoubtedly creates interest and keeps it from becoming boring, as those of you who do or have done general practice will have to agree.

The Author

- **W. Edward Duling, M. D., 401 Medical Arts Building, Charleston, W. Va.**

Historic Role in Modern Dress

Within the past four or five years, we have found that the general public is becoming more and more receptive to the idea of a family doctor. We have assumed the role of a bridge between the patient and the hospital or the specialist. Conversely, most specialists today are manifesting more than mere tolerance with regard to the general practitioner. Once the general public began to realize the impossibility of any one physician's being able to manage all phases of all medical problems, we could begin to make referrals in the happy absence of that certain air of reluctance on the part of the patient. I have found that patients rarely, if ever, feel that they have been sloughed off into another doctor, or that a referral is an admission of failure on the physician's part; instead they seem to accept it as a measure of expediting treatment or of providing them with a better and more modern form of therapy. Actually, in my own practice, I can almost count the number of referrals to other physicians in which the patients have not returned and, usually, they have returned gratified and with a greater respect for my judgment. In general, it has seemed to create the feeling that chances are not being taken with their health just to satisfy personal pride or pocketbook.

*Presented before a staff meeting at McMillan Hospital in Charleston, W. Va., May 15, 1964.
Submitted to the Publication Committee, June 5, 1964.

It is not uncommon nowadays to hear it voiced that physicians are becoming cold, impersonal or mercenary. It it is difficult, however, for a doctor to establish harmonious, warm relations with a patient on one or two visits. Take surgery for example: one consultation, one examination, then an operation and a few postoperative visits, whereas, on the other hand, the psychiatrist or the obstetrician can build up slowly and gradually good relations and establish excellent rapport.

I am sure that very few general practitioners are worried about the statement that the family doctor is a "has been." It is true that eventually we may be replaced by the internists but before that there will have to be quite a few more obstetricians, pediatricians and geriatricians. Here in Charleston, most general practitioners enjoy good harmony with the specialists and I have never felt that we function as a catch-all or waste basket for the unwanted neurotics or crocks although we, as does everyone else in medicine, enjoy our share. Neither do we function as a chamber of commerce or a referral agency. Actually, I feel that we are in an enviable position in that what we cannot diagnose or treat can be referred.

Economic Level of Clientele

The clientele of the average general practice is drawn from a cross section of the community which is economically healthy and sound. Very few general practitioners have to depend on any one group for a livelihood and that means everything from DPA to bankers, inclusive.

With the so-called shortage of physicians, our group is currently feeling the pinch, especially in Kanawha Valley, since the numerical ratio of general practitioners to specialists is so low. Economically, this is excellent from our point of view because it makes us more in demand, but it also forces some of the specialists to do varied types of general practice such as insurance examinations and routine employment physicals. If we can induce more general practitioners to settle in the Kanawha Valley, thus changing the existing ratio and creating more competition in general practice, the public should benefit from a better brand of medicine. The American Academy of General Practice is continually trying to encourage more physicians in this field.

Role of GP in Hospital

With respect to the role of the general practitioner in this hospital, I asked Mrs. Byrant to pull the records of all admissions by general practitioners for the month of April. These embraced the records of eight physicians. The total number of hospital admissions for April was 455 and she pulled 48 charts, a rate of almost 11 per cent. The types of cases treated were mainly medical, the largest number being pulmonary, both acute and chronic, a total of 15 cases or one-third of the general practice admissions for that month. The next most prevalent condition was gallbladder disease with a total of 7 cases; the remainder of the admissions included everything from psychoneurosis to diabetes mellitus. There was only one delivery as noted, and I was gratified to note that there were no deaths. These charts were only the completed ones, so my percentages may not be strictly accurate. The average patient stay was 6.5 days. It was surprising to note that there were only seven consultations requested: four medical, two surgical and one urological. Of the 48 admissions, there were 94 x-rays performed and 25 electrocardiograms. I do not know what these figures would mean to a statistician but to me they mean that we are still in there plugging.

Ours is the only country deliberately founded on a good idea.

JOHN GUNTHER.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

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The President's Page

THE CRISIS HAS ARRIVED

"THE history of liberty is the history of the limitation of governmental power, not the increase of it."—Woodrow Wilson.

I write this from Chicago in the midst of a conference on the crisis that confronts Medicine. Dr. Donovan F. Ward has spoken and Dr. Edward R. Annis has just finished his remarks. Decisions have been made which will affect you directly. The House of Delegates of the American Medical Association is being called into an extraordinary special session the first week in February. Additional decisions and policies will be made, but one thing remains certain, the fight to prevent the socialization of our profession, which directly affects every one of our patients—really all the American people—shall definitely be continued.

Doesn't it seem rather unusual that all of the Administration's other health proposals are planned to be financed by general tax funds; yet, meanwhile insisting that medical aid for those over 65 irrespective of need, should be financed by a special increasing *payroll tax* to be assessed on the younger workers and the employer with no real assurance that this will take care of their health needs when they reach the age of 65? Is America asleep—or is the Administration's "something for everyone" society really hypnotic?

An immediate campaign to educate both physicians and our patients about Kerr-Mills and implementation of Kerr-Mills to make it more workable and more easily available to those eligible over 65 are some of our concerns. The easing of the means test but retaining the principle of helping those who actually need this help continues to be our goal. Surely, when all the facts are known, there must be some reasonable, patriotic and dedicated Americans in this new Congress who will listen to our patients, the American People. Or is this really a dimming hope? Our cause is just and has remained so throughout these years, yet one that each and every one of us will and must fight to uphold down to the final hour. We have been engaged in a fight to preserve freedom from socialism for all Americans, not solely for ourselves, and may God see fit to aid us in this time of great strife. Let us go forth to do battle and uphold our righteous convictions down to the final hour. You shall be informed.

Next month as the Auxiliary honors Doctor's Day, I am asking that this President's Page be written by the President of the Woman's Auxiliary.

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

PRESCRIPTION LABELING—PRO AND CON

"Please label as to contents." These 5 words on every prescription can avert confusion, help the patient understand his illness and its treatment more fully, and provide another physician with necessary information at any time.

PLEASE LABEL AS TO CONTENTS

Less than a generation ago it was considered improper to tell the patient the nature of his medicine. The mystery of the Latin name, the piquance of the odor, and the bitterness of taste all added to the "magical" healing powers of our potions. Besides, this prevented the patient from becoming too inquisitive and even challenging the doctor's judgment in selecting a particular elixir.

Mystery and magic have largely vanished from drug therapy, however. We can now use medications which are quite specific in their actions. Even those with "nonspecific, anti-inflammatory actions" are backed by sufficient testing and study to warrant our confidence. We no longer need to hide their names or composition from the patient.

Our patients have changed, too. They have become more sophisticated than ever before regarding their own bodies and illnesses. Not only do they have more basic knowledge of physiology, but they also read more. The popular magazines and daily newspapers keep them remarkably up-to-date. They do discuss their treatment, and they are no longer satisfied with remedies unknown to them or unexplained. We should be aware that satisfaction is part of successful treatment.

When the patient consults another physician he should be able to indicate precisely what medicine he has been taking and in what dosage form. How unnerving it is to watch a lady from out of town carefully unload all the medicines from her pocketbook onto your desk. You know she expects you to recognize each—and you know you never will.

Wrestling with the size-shape-color guide issued by the AMA will convince you after the first hour that you are incompetent, inept, and unable to follow directions. Somehow, the pill you carefully measured in all diameters, crushed and examined, fits none of those named. Sometimes it could be any of several.

It is even hard to keep track of all the medications your own patients are taking. It is bad enough in the office when someone asks, "Should I keep on taking the orange pill?" You wonder if he means the Tetracyn® or the Vi-Dexemin.® When he calls you at home, though, and asks the same question, there is often no answer. How

much easier it would be if he asked, "Shall I continue the Tetracyn?"

It will save the physician's time and avoid needless confusion if prescription blanks are printed with these 5 extra words: "Please label as to contents."—*Robert R. Montgomery, M. D., in Medical Annals of District of Columbia.*

(Ed. The following term appears in pharmaceutical Latin books: "S.N.P.—signetur nomine proprio"—let it be labeled with its own name).

SIX REASONS WHY THE DRUG LABEL SHOULD NOT APPEAR ON Rx LABELS

More and more physicians are requesting that the drug name automatically appear on the prescription label—unless they specify that it should not. There are at least 6 reasons why it is *not* advisable to automatically place the drug name on the prescription label. Here are the reasons:

Reason No. 1: The physician arrives at a proper diagnosis via a very complex procedure that earns him the respect of his patients. This complex procedure is *oversimplified* when it is reduced to merely the name of a drug on a label.

Reason No. 2: Newspapers and magazines are loaded with often-exaggerated reports on adverse drug reactions and toxicity, causing our present drug hysteria. These reports mention the name of drugs. For example, if the millions of users of Parnate and their families had recently read the exaggerated reports about the drug in the newspapers, they would have become unduly alarmed—if the name of this valuable drug had appeared on their Rx labels. The same applies to the millions of Enovid users and their families, when the public press *erroneously* linked the drug to cancer in humans.

Reason No. 3: When a patient knows the name of a drug, he or she can put pressure on the physician. For example, 2 women—both patients of a drug-name-on-the-label MD—brought in Rxs at about the same time to a pharmacy in Illinois. One inquired of the other: "What did Dr. X prescribe for you?" Upon hearing the drug name, the inquirer urged: 'Don't take it. It did me no good." The other lady then phoned the doctor, and urged him to prescribe another drug!

Reason No. 4: Even physicians who favor placing the drug name on the label often say that there are exceptions to this rule—conditions under which the drug name should *not* be on the label. When a physician makes such an exception, the patient may say to himself: "I wonder if I have a serious disease, like cancer?" . . . or "Is the doctor giving me a barbiturate or a narcotic?"

Reason No. 5: When a patient knows the name of a drug, it often leads to self-medication and to patient-prescribing for others. If the drug happens to be a "prescription only" drug and the pharmacist says that he cannot supply it without specific permission from the doctor, some people may suspect physician-pharmacist collusion.

Reason No. 6: Patients who know the names of the drugs prescribed for them will tend to price-shop—by asking for the drug by name. With all the look-alike and sound-alike drug names—coupled with the many forms and dosage strengths—the patient may get the wrong drug or the wrong strength.

To sum up the situation: The physician should retain full control of therapy in the interest of public health. When he specifies that the name of the drug be placed *automatically* on the Rx label, he tends to lose control of that therapy. This is not in the interest of an effective physician-patient-pharmacist relationship.—*Irving Rubin, R. Ph., in American Professional Pharmacist.*

In Defense of Innocence

We most warmly welcome the advent of legislation designed to protect from suit the physician who reports suspected parental abuse of children. It has been one of the greater ironies of our tragic age that the physician, after devoted care of a mysteriously ill or injured child, has had at last to deliver him up to his parental tormentors because proof of their criminality was impossible to adduce.

The problem of parental cruelty lies in the soul of man, for man alone among earth's creatures is capable of intelligent savagery toward his very offspring. Some of us choose to ignore the evil through horror or convenient disbelief. In others indifference is itself perhaps a whiff of the fullblown malignity. Is it not monstrous that a nation which reacts with revulsion to the tugging of a pair of canine ears is incapable of interest, let alone fury, when confronted with the facts of child abuse? Perhaps in labeling this problem the "battered child syndrome," a neat, cool, bland, clinical designation, we are attempting to mitigate for ourselves the terrible realities. Let us hope that the physician himself will not be so detached as the label, that he will energetically rise to the defense of the small patient who has obviously been maltreated. After all, would not the rescue of a single helpless child from this ultimate despair be for most of us an act greater by far than all our works?—Westchester Medical Bulletin.

GENERAL NEWS

Winter Meeting of Council Held In Charleston on Jan. 3

The Council of the West Virginia State Medical Association unanimously approved several bills which had been prepared for introduction in the regular 60-day session of the West Virginia Legislature. The first session of the 57th Legislature was convened at The Capitol in Charleston on January 13.

The Council also approved several other legislative bills during the winter meeting which was held at the Daniel Boone Hotel in Charleston on Sunday, January 3. A meeting of the Legislative Committee was held on Saturday evening, January 2.

Mental Health Bill Approved

The Council officially endorsed a bill which would revise portions of the Code pertaining to the admission and discharge laws of the mentally ill. The bill is designed to modernize the State's somewhat antiquated "commitment" law to change the concept of the mentally ill person from being criminal in nature to one of medical. Mentally ill persons would be "patients" instead of "inmates" and would be "hospitalized" instead of "committed."

The recommended revisions in the mental health law resulted from a study of modern laws enacted in other states and following consultation with officials of the mental health departments of neighboring states.

The mental health bill also has been endorsed by the West Virginia Association for Mental Health and the State Department of Mental Health. The same legislation was passed by the House of Delegates but died in the Senate during the 1963 session.

Other Legislation Approved

The Council also voted to approve several other bills of interest to the medical profession. It was expected that the following bills would be introduced early in the session:

"Child Abuse" Legislation. This proposal relates to the conferring of immunity upon physicians, professional personnel, school teachers, institutions and others who report certain physical abuse of children.

It was pointed out that recognition of the "battered child" is occurring with increasing frequency as the clinical description of such children is receiving more and more publicity both in professional literature as well as lay literature.

Many other states have enacted similar legislation which makes it mandatory to report suspicious incidents and also protects the person reporting the incident.

Bill Relating to Receipt of Confidential Information. This bill would provide protection from liability for individuals or groups engaged in medical study for research and for the purpose of reducing morbidity or mortality. The State Health Department, together with the Committee on Maternal and Perinatal Fetal Welfare of the State Medical Association, are involved in a continuous study of hospital charts of patients to research the area of cause and possible ways to reduce morbidity or mortality.

Enactment of this legislation would provide exemption for legal liability for those furnishing such information and for those studying and publishing the results and summaries.

Administration of Medical Welfare Programs. A bill was prepared by a legislative sub-committee in December which would give authority to the Department of Welfare to contract with non-profit or commercial insurance companies to administer, furnish or provide all or any part of the medical services provided for medical welfare recipients in West Virginia.

This proposal had been under study by a subcommittee of the Legislative Interim Committee during the past two years and the Committee considered the bill in its final form at a meeting prior to the session.

The Department of Welfare cooperated fully in this study and the other interested and participating groups included the West Virginia State Medical Association, the West Virginia Hospital Association, the American Medical Association, the American Hospital Association, the National Association of Blue Shield Plans, the Blue Cross Association and the U. S. Public Health Service.

"Good Samaritan" Bill. The "Good Samaritan" bill would provide physicians and laymen immunity from liability in connection with rendering emergency care to injured persons at the scene of an accident.

This bill was not drafted by the State Medical Association but the Council voted to support this legislation when it is introduced in the 1965 session. The same bill was passed by the Senate in 1963 but died in the House Judiciary Committee.

Vital Statistics Bill. This legislation is actually a model bill and would aid the State Health Department in its operation and maintenance of a statewide system of vital statistics reporting and recording.

Election of Honorary Members

The following physicians were elected to honorary membership in the State Medical Association:

Physicians	*Address*	*Society*
Paul P. Warden	Grafton	Taylor
A. V. McCoy	Elm Grove	Ohio
Raymond A. Tomassene	Wheeling	Ohio
M. B. Williams	Wheeling	Ohio

Installation of TWX Service

The Council approved installation of a teletypewriter communications service in the headquarters offices. The TWX equipment has been installed and it is anticipated that the system will provide automatic and more efficient communications between the state office and the AMA and other state medical associations.

The service was approved by the AMA House of Delegates during the clinical convention and that organization assumed the cost of installation and also the annual rental costs for the equipment. The State Medical Association will pay only for those messages transmitted from the headquarters offices.

Report of Medical Economics Committee

Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee, reported in detail concerning recent activities of the various subcommittees of the parent committee.

He reported that members of the Sub-Committee on Workmen's Compensation met with Commissioner Cletus B. Hanley on December 9, and that another meeting had been arranged tentatively for January 27.

Doctor Callender also discussed the proposed Relative Value Index, the Medicare (ODMC) program and the medical programs administered by the Department of Welfare.

At the conclusion of Doctor Callender's report, the Council went on record unanimously as reaffirming its faith in the Medical Economics Committee and commending the Chairman and the members for their diligent and untiring work.

The Council meeting was attended by Dr. Charles L. Goodhand of Parkersburg, Chairman; Dr. Albert C. Esposito of Huntington, President; and Drs. Maynard P. Pride, Morgantown; Andrew J. Weaver, Clarksburg; John E. Echols, Richwood; I. Ewen Taylor, Huntington; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; and D. Alene Blake, Oak Hill; and Mr. William H. Lively, Executive Secretary.

The meeting also was attended by Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington, AMA Delegates; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. N. H. Dyer of Charleston, State Director of Health; Dr. George F. Evans of Clarksburg, Editor of *The Journal;* Dr. W. Fred Richmond of Beckley, Chairman of the Nurses Liaison Committee; Dr. John W. Hash of Charleston; Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. George A. Curry of Morgantown; Mrs. George A. Curry of Morgantown; President of the Woman's Auxiliary; and Mr. William E. Mohler of Charleston, Attorney for the Association.

Dean Clark K. Sleeth Appointed To Harvard Visiting Committee

Dr. Clark K. Sleeth of Morgantown, Dean of the West Virginia University School of Medicine, has been appointed a member of the Visiting Committee for the Harvard University Health Services.

Clark K. Sleeth, M. D.

The appointment, made by the Harvard University Board of Overseers, is for a six-year term. The Visiting Committee consists of 15 members from various professions and businesses. Its function is to provide objective review of the work of the Harvard University Health Services and to offer suggestions for possible improvements.

Doctor Sleeth was also named a member of the State Advisory Council to the Hospital and Medical Facilities Program by Governor W. W. Barron.

The Council "consults with and advises" the State Department of Health in matters dealing with the Hill-Burton Act, which is designed to help individual states finance construction of public and non-profit hospitals and related medical facilities.

Doctor Sleeth was appointed Dean of the WVU School of Medicine on January 1, 1961, succeeding Dr. E. J. Van Liere, who retired after more than 40 years as a member of the School of Medicine faculty.

He was graduated from West Virginia University and attended the two-year WVU School of Medicine. He received his M. D. degree in 1938 from the University of Chicago School of Medicine.

Following an internship and residency at the Henry Ford Hospital in Detroit, Michigan, 1938-41, Doctor Sleeth returned to the University in 1941 as Assistant Professor of Medicine.

During World War II he served with the Medical Corps of the United States Army Air Corps and in 1948 was appointed Associate Professor of Medicine.

Another $500 Contribution To Scholarship Fund

Mr. Harry H. Carnahan, President of The Medical Arts Supply Company in Huntington, has made a contribution of $500 to The Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association. This is the seventh consecutive year that Mr. Carnahan has contributed the sum of $500 to the Scholarship Fund.

Under the program, ten students already have been awarded scholarships of $4,000 each to the West Virginia University School of Medicine.

Dr. Martha Jane Coyner Named To Sears Foundation Board

Dr. Martha Jane Coyner of Harrisville, Chairman of the West Virginia State Medical Association's Committee on Rural Health, has been named to a four-year term on the Medical Advisory Board of the Sears-Roebuck Foundation. The appointment was announced in Chicago by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association.

Four other physicians were also named to the Medical Advisory Board by the Board of Trustees of the AMA. They are as follows:

Dr. George P. Archer of Prestonsburg, Kentucky, President of Kentucky Medical Association.
Dr. Thomas S. White, Boulder City, Nevada.
Dr. W. Linwood Ball, Richmond, Virginia.
Dr. Glen R. Peters, Kansas City, Kansas.

Membership to the Advisory Board rotates every two years with one half of the Board retiring at that time. Administratively, the Board is divided into five geographical territories nationally. There are two members of each area. Current nominees will not start their terms until after the June meeting of the AMA in New York City.

Doctor Coyner is a native of Buckhannon and was graduated from West Virginia University. She attended the two-year School of Medicine at WVU and received her M. D. degree in 1952 from the University of Pittsburgh School of Medicine. She served an internship at the Ohio Valley Hospital in Wheeling, 1952-1953, and was licensed to practice in West Virginia that same year.

She has served for a number of years as a member of the Committee on Rural Health and has been active in the West Virginia Chapter of the American Academy of General Practice.

New Association Members

Dr. Sergio A. Payuyo, 396 Dingess Street, Logan (Logan). Doctor Payuyo was born in the Philippines and received his M. D. degree in 1949 from the University of Santo Tomas in Manila. He interned and served a residency at the Youngstown Hospital Association in Youngstown, Ohio, 1954-58. He also served residencies at McMillan and Mountain State Hospitals in Charleston, 1958-59. He was licensed to practice in West Virginia in 1964 and he is engaged in general practice.

* * * *

Dr. William S. Sheils, Cabell-Huntington Hospital, Huntington (Cabell). Doctor Sheils, a native of Huntington, was graduated from Marshall University and received his M. D. degree in 1960 from the Medical College of Virginia. He interned at Mercy Hospital in Springfield, Ohio, 1960-61, and served residencies at Cabell-Huntington Hospital and the Marion County General Hospital in Indianapolis, 1961-64. His specialty is internal medicine.

Some men succeed by what they know—some by what they do; and a few by what they are.—Elbert Hubbard.

Raleigh County Medical Society Gives $7,660 to YMCA

The Raleigh County Medical Society recently presented $7,660.51 to the YMCA of Beckley-Raleigh County as the beginning of a building fund.

The contribution represented funds left over from the Society's highly successful Sabin Oral Polio immunization program.

Dr. Richard G. Starr, secretary-treasurer of the Society, made the presentation at the annual YMCA Banquet in behalf of Dr. B. B. Richmond, the president.

Mr. Warren A. Thornhill, III, president of the YMCA, stated that the "Society's action in this matter certainly demonstrates to us and to the public at large that yours is a profession which is interested in the city, the community and the county."

Dr. Richard G. Starr, right, secretary-treasurer of the Raleigh County Medical Society, is shown presenting a check for $7,660.51 to Mr. Warren A. Thornhill, III, president of the YMCA of Beckley-Raleigh County. The presentation was made at the annual YMCA Banquet in Beckley.

Dr. Robert A. Jenkins Assumes Duties At W. Va. Training School

Dr. Robert A. Jenkins recently assumed his duties as superintendent of the West Virginia Training School near St. Marys. He succeeds the late Dr. Colin A. Anderson, who died on September 22.

A native of Niles, Ohio, Doctor Jenkins formerly served as Chief of Out-Patient Service at a Veterans Administration Hospital in Topeka, Kansas.

He was graduated from Kent State University and received his M. D. degree from the Western Reserve University School of Medicine in Cleveland, Ohio. He served psychiatric residencies at the Duke University School of Medicine, the Topeka VA Hospital and the Menninger School of Psychiatry.

Tuberculosis Still a Problem In West Virginia

More than 1,596 cases or suspected cases of tuberculosis with 637 newly confirmed cases were uncovered in West Virginia during 1964.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health," discussed the growing problem of tuberculosis in West Virginia. The State Health Department's x-ray mobile unit also has uncovered 397 tumors and 1,991 other abnormalities this year.

Doctor Dyer pointed out that among all states, West Virginia ranks 12th in deaths, 13th in new cases. As a leading cause of death in the state, tuberculosis ranks 12th in 1963. It continues as the leading cause of death from infectious disease.

"During the ten years from 1953 to 1963," Doctor Dyer said, "the mobile units produced 1,131,310 x-rays, revealing 11,497 cases or suspected cases of tuberculosis, 2,179 lung tumors, 2,732 cardiovascular defects, and 8,247 other chest abnormalities."

Doctor Dyer explained that for more than 20 years the federal government has paid the entire cost of operating two mobile chest x-ray units in the state. Now federal aid will be increasingly diverted into special tuberculosis projects, similar to the ongoing program in 19 southern counties. States are now expected to assume their share of the cost for the operation of the mobile units. A request of $77,500 has been made to the Legislature to continue their operation and to replace one unit that is 15 years old.

New Health Programs

In another issue of the publication Doctor Dyer discussed several health programs which will be extended or initiated in 1965.

He noted that a second mobile clinic will soon be put to use in maternal and child health programs supplementing the work of the first unit purchased two years ago. The first mobile unit has been employed as an educational medium for mothers and children in special events throughout the state and is being used to bring health services to rural and depressed areas. The unit is presently being used in a county by school health survey and was used as a clinical facility at the Centennial National Youth Camp in 1963.

"With financial support from the Vaccination Assistance Act," Doctor Dyer said, "intensive immunization programs against polio, tetanus, diphtheria, smallpox, and pertussis will be underway in at least 26 counties by early spring." Within the year intensive campaigns will be underway or will have been completed in all 55 counties. The program is aimed at conditioning parents to take their children in infancy to their family physician for vaccinations.

During 1965-66-67, definite improvements in transportation and immediate care for emergency patients will result from a special project supported by a grant of approximately $44,000 from the U. S. Public Health Service.

Doctor Dyer explained that about $3 million in federal Hill-Burton matching funds, on a dollar-for-dollar basis, will be available for construction of new hospitals and other medical facilities during the year. On July 1, 1965, additional support for this program will be forthcoming as a result of new legislation that provides aid to institutions in renovating and modernizing existing facilities.

In another issue he discussed plans for launching a comprehensive program to reduce medical and dental radiation exposure through educational and technical services. Plans are also being made to intensify surveillance of contaminants in water, milk and other food.

Doctor Dyer said that although the over-all, long-term effects on health from increasing cumulative exposure to ionizing radiation are still largely undetermined, authorities recognize that now is the time to institute effective control programs. More than three years ago, Congress approved the first specific appropriation for radiological health, encouraging the states to do something about their problem by offering matching funds on a dollar-for-dollar basis. Thus far, no funds in West Virginia have been approved for the program, but $18,880 is being requested for the 1966 fiscal year to match anticipated federal aid.

ACP Golden Anniversary Session In Chicago, March 22-26

The Golden Anniversary Session of the American College of Physicians will be held at the Conrad Hilton Hotel in Chicago, March 22-26. More than 300 physicians and other medical scientists are expected to take part in the five-day scientific program.

Highlights of the meeting will be presentations by prominent internists who received top awards from the College in 1933, 1949, and 1957, and an emphasis on the relationship of psychiatry and internal medicine.

Dr. A. Carlton Ernstene of Cleveland will be installed as President of the College during the meeting, succeeding Dr. Thomas M. Durant of Philadelphia.

Several hundred physicians will be inducted into the ACP at the annual convocation.

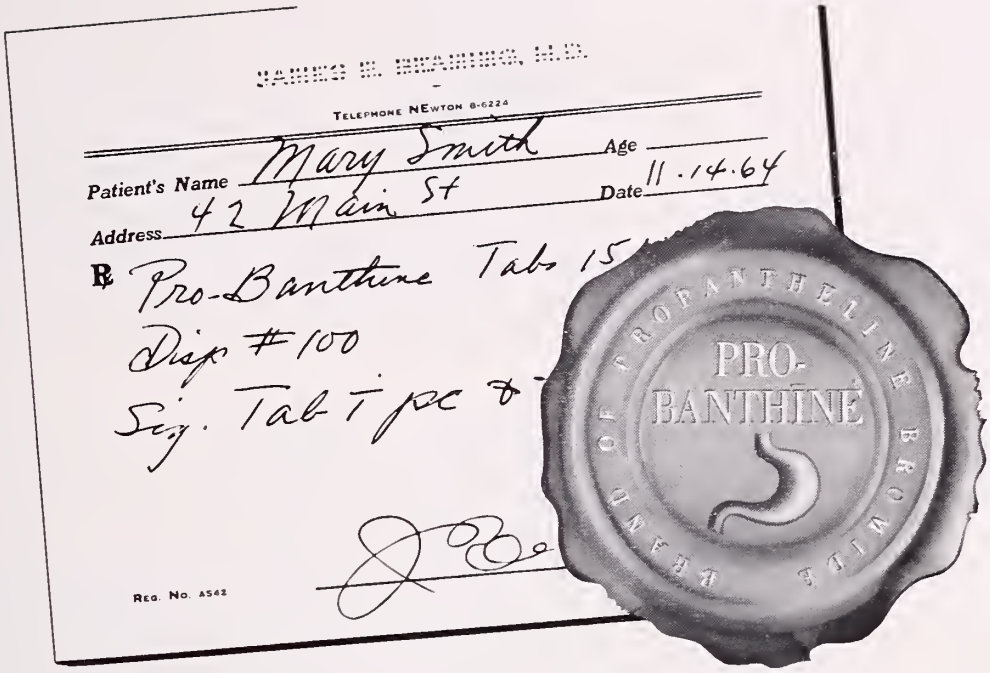
Fund Established to Aid Family Of Dr. Paul E. Carlson

Establishment of the "Physician's Aid Carlson Fund" to aid the family of Dr. Paul E. Carlson, who was killed on November 24 by rebel forces in the Congo, was announced recently by the Los Angeles County Medical Association.

All donations received will be used for the benefit of Doctor Carlson's widow and two children. All expenses for operating the fund will be borne by the Los Angeles County Medical Association and the Physician's Aid Association.

Doctor Carlson, who operated a 65-bed hospital in Waloso in the Congo, had been in the country one year. He was one of 50 American and Belgian hostages massacred in Stanleyville by fanatical rebels.

Physicians desiring to make a contribution should make checks payable to the Physician's Aid Carlson Fund, and mail same to 1234 North Vermont, Los Angeles, California.



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Historically, reduction of acid and motility in peptic ulcer has been approached through the use of antacids, dietary management and surgery.

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So dependable have these actions been that now, for many, standard treatment of peptic ulcer and several allied conditions has become antacids *plus* Pro-Banthīne, dietary management *plus* Pro-Banthīne, surgery *plus* Pro-Banthīne, or some combination of the three.

Pro-Banthīne has become the most widely prescribed anticholinergic for patients with peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia because patients respond favorably to its therapeutic actions.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six tablets daily in divided doses. In severe conditions as many as four tablets may be given four times daily. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE
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Research in the Service of Medicine

WVU Medical Center
–News–

LINDA Donelle Lewis, a senior in the West Virginia University School of Medicine, has begun 12 weeks of work at the Christian Hospital in the small farming town of Mungeli, India.

She is one of 29 American students who were awarded Smith, Kline & French Laboratories Fellowships for study abroad.

A native of Beech Bottom in Brooke County, Miss Lewis left for the Far East on January 15 with intermediate stops in Honolulu, Tokyo, Hong Kong, Manila and Calcutta.

Linda Donelle Lewis, a senior in the WVU School of Medicine, is shown discussing her 12-week tour of duty at a hospital in the small farming town of Mungeli, India, with Dean Clark K. Sleeth. Miss Lewis left for India on January 15 and will return to the United States the latter part of May.

She arrived in Bombay, India, on January 26 and journeyed to Balispur by train and on to Mungeli by car. The town is in the center of a group of hundreds of small villages with a total population of 250,000.

Her work in Mungeli will be completed on April 21. Visits are scheduled on the return trip to Madras. Delhi, Agra, Kashmir, Teheran, Athens, Rome, Frankfurt, Berlin, Paris, London, Belfast and Glasgow.

Receive Birth Defects Grant

Two members of the WVU School of Medicine faculty recently received a $76,565 grant from the National Institutes of Health to investigate birth defects.

Dr. Nicholas W. Fugo, Professor and Chairman of Obstetrics and Gynecology, and Dr. Roy Butcher, an Instructor in Obstetrics and Gynecology, will continue for a three-year period research that has been supported for the past 18 months by the Association for the Aid of Crippled Children.

Birth defects are believed caused by a faulty combination of chromosomes from the ovum and sperm. Some believe that such defects are caused, at least in part, by the fertilization of the ovum when it is overripe. Doctors Fugo and Butcher seek to find whether this will produce abnormalities in rodents.

• Compiled from material furnished by Arthur V. Cierva, Director, Medical Center News and Information Services, Morgantown, West Virginia.

Dogs Live with "Borrowed" Kidneys

Two dogs are living on borrowed kidneys in the animal quarters at the Medical Center. One received a new kidney nine months ago and the other five months ago. Both are doing well.

Dr. Eugene LaPlante, a resident in surgery and a member of the research team that did the transplants, said it is unusual to have two dogs whose kidneys have functioned for such long periods of time. Normally, transplanted kidneys can keep a dog alive for about ten days. This can be prolonged for from two to three weeks by using certain drugs and other pretreatment methods. The longest a dog has lived with a transplanted kidney is 739 days.

Also working with Doctor LaPlante on the research project are Drs. Kenneth Thomas and Alvin L. Watne of the Department of Surgery and Dr. Richard Chamberlain of the Department of Pathology.

Doctor LaPlante said that the team is interested in learning why a few dogs accept borrowed kidneys for longer periods than others. The dogs are checked daily by the researchers and continue to live in the same room with other dogs and eat the same food. They still play when taken outside for exercise.

More than 5,000 research animals are housed in the animal quarters for use in studies of various diseases.

Dean Clark K. Sleeth has been named a member of the State's Emergency Resources Planning Committee. On the committee he is serving as a member of a supporting unit, the Task Group on Health. The committee, organized by executive order, is assisting in the coordination and direction of the State emergency resources planning program.

oing better, Mrs. Smith?

My, yes! I'm not tired out anymore.

Headaches still bother you?

t all. I feel wonderful!

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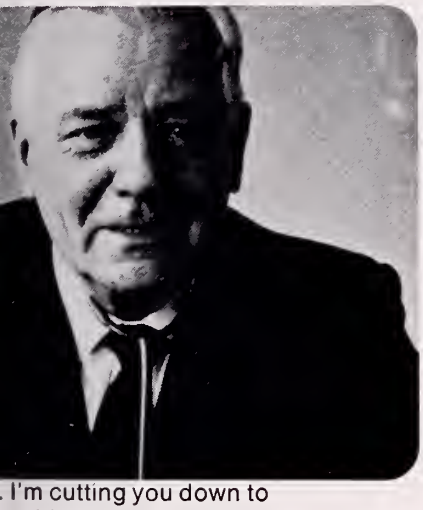
One a day at breakfast. Sure is easy on me.



. I'm cutting you down to a tablet daily.

Thanks for everything, Doctor. See you on the 3rd.

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autions: Reduce dosage of concomitant anti-tensive agents by one-half. Discontinue if UN rises or liver dysfunction is aggravated. rolyte imbalance and potassium depletion occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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The Month in Washington

PRESIDENT JOHNSON has asked Congress to approve a far-reaching program of diagnosis, treatment and stepped-up research on heart disease, cancer, stroke and "other major diseases." In a health message to Congress, the President also urged speedy passage of a social security health plan for aged persons.

The outline of his wide-ranging program was the President's first message on legislation sent to the new Congress. He sent it to Capitol Hill on the fifth day of the new session.

Johnson requested in addition to "Medicare":

—An increase in federal funds for maternal and child health and crippled children's services and broadening of public assistance programs so federal money could be used to pay medical and dental costs for children of needy families.

—Approval of a five-year program of grants to help start community mental health centers to offer comprehensive services.

—A step-up in the program to rehabilitate disabled persons so 145,000 could be restored to useful work each year.

—Establishment under a five-year program of multipurpose regional medical complexes for diagnosis and treatment of heart disease, cancer, stroke and other major diseases. This proposal envisions a network of 32 centers coordinating efforts of medical schools, hospitals and community facilities costing an estimated $1.2 billion.

—Federal funds to improve services for the mentally retarded, increase hospital modernization and start a new program of loans and guarantees for loans to help voluntary associations build group medical practice centers.

—New legislation to help medical and dental schools cover basic operating costs with federal funds.

—Federal scholarships for medical and dental students.

—Extension for five years after mid-1966 of federal health research programs with a greater emphasis on specialized research of a national or regional nature.

—Laws to bring the production and distribution of so-called "goof-ball" pills—barbiturates, amphetamines and other psychotoxic drugs—under tighter control and legislation to require adequate labeling of hazardous substances and safety regulation of cosmetics and therapeutic devices by the Food and Drug Administration.

• From the Washington Office of the American Medical Association.

Prior to the health message, Sen. Clinton P. Anderson (D., N. M.) and Rep. Cecil R. King (D., Calif.) already had introduced medicare legislation to carry out the President's program. It was S-1 in the Senate and HR-1 in the House. It was a modified version of the King-Anderson bill which died in a joint House-Senate conference committee last year after the Senate had voted 49-44 to add it to a House measure increasing social security cash benefits.

The new King-Anderson bill calls for bringing self-employed physicians under social security coverage. It also would increase social security cash benefits by seven per cent. In a benefit period, all persons 65 years or older would be eligible under the health care plan for 60 days of hospitalization with the patient paying for the first day and 60 days of post-hospital care in a nursing home. Generally, 90 days would have to intervene between benefit periods. Aged persons also would be eligible for up to 240 days a year of home health services, such as a visiting nurse, and certain outpatient diagnostic services with the patient paying a monthly deductible. Nursing home benefits would start January 1, 1967, and the other benefits July 1, 1966.

Social security taxes would be increased by .3 per cent next year, .38 per cent in 1967-68 and .45 per cent in 1969 and following years on employees and employers for a separate fund to finance the program. The tax base also would be increased to $5600.

The program would be administered through social security by the Secretary of Health, Education and Welfare. Hospitals could elect to be represented by a private organization, such as Blue Cross, to negotiate their contracts. The secretary would also delegate to such organization the functions of receiving payments from the social security program. Payments would be made to hospitals and other providers of services on a cost basis. The cost of hospital services would be based on semi-private accommodations (2, 3, or 4-bed rooms).

The bill also would authorize creation of an association of private insurance carriers to sell, on a nonprofit basis, approved policies covering health costs not covered under the social security plan. Participating carriers would be exempt from anti-trust laws.

Obituaries

WYLIE H. CUNNINGHAM, M. D.

Dr. Wylie H. Cunningham, 84, of Beckley, died on January 7 at a hospital in that city.

Doctor Cunningham received his M. D. degree in 1906 from the Medical College of Virginia and was licensed to practice medicine in West Virginia that same year. He practiced for 23 years in the Beaver and Blue Jay areas before moving to Beckley in 1929.

He was an honorary life member of the Raleigh County Medical Society, West Virginia State Medical Association and the American Medical Association. He served for more than 40 years as a member of the Board of Directors of the Raleigh County Bank.

Besides his widow, he is survived by two sons, Kenneth and Howard, both of Richmond, Virginia; a sister, Mrs. C. L. Harlan of Huntington; and one grandchild.

* * * *

ROBERT B. GRIMM, M. D.

Dr. Robert B. Grimm, 59, of Cameron, Marshall County, died on January 1 in that community.

He was born on July 6, 1905, in New Freeport, Pennsylvania, the son of Francis Roscoe and Norine Williams Grimm. He attended the two-year West Virginia University School of Medicine and received his M. D. degree in 1929 from the Medical College of Virginia.

He served his internship at Ohio Valley General Hospital in Wheeling, 1929-30, and had practiced medicine in Littleton and Cameron since that time. He was a member of the Marshall County Medical Society and the West Virginia State Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Helen Speery of Fairfax, Virginia; two brothers, the Rev. Fred Grimm of Washington, Pennsylvania, and John Grimm of New Freeport, Pennsylvania; and three grandchildren.

* * * *

JAMES ANDREW McCLUNG, M. D.

Dr. James Andrew McClung, 90, of Richwood, died on January 7 at a hospital in Ripley after a brief illness.

Doctor McClung, who served a four-year term in the State Senate during the administration of the late Gov. Henry D. Hatfield, established the McClung Clinic in Richwood in 1905, which is now operated by a son, Dr. James E. McClung.

He was born on September 29, 1874, in Rupert, Greenbrier County, a son of Joseph Edward and Kathryn McClung. He was graduated from West Virginia University and received his M. D. degree in 1901 from Baltimore Medical College (now University of Maryland School of Medicine).

He was an honorary life member of the Central West Virginia Medical Society, the West Virginia State Medical Association and the American Medical Asso-

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PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

ESTHER L. SIMPSON, R.N.
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ciation. He was a past president of his local society and served a term as first vice president of the State Medical Association.

Besides his widow, he is survived by two sons, Dr. James E. McClung of Richwood and Dr. William D. McClung of Ripley; four daughters, Miss Beatrice McClung and Mrs. Margaret Johnson, both of Charleston, Mrs. Kathryn Welch of Rupert, and Mrs. Ruth Nellen of Green Bay, Wisconsin; 15 grandchildren and 4 great grandchildren.

* * * *

D. GARDEN PRESTON, M. D.

Dr. D. Garden Preston, 86, of Lewisburg, died on January 9 at a hospital in Ronceverte after a brief illness.

Doctor Preston had retired in 1957 after 50 years of active practice. He had been a practitioner in Greenbrier County for more than 41 years.

He was born on September 20, 1878, in Glade Hill, Virginia. He was graduated from Roanoke College and received his M. D. degree in 1907 from the College of Physicians and Surgeons in Baltimore (now the University of Maryland School of Medicine). He took postgraduate work at several hospitals in New York City.

He was an honorary life member of the Greenbrier Valley Medical Society, West Virginia State Medical Association and the American Medical Association. He served as secretary and president of his local society and also served a term as first vice president of the State Medical Association.

Besides his widow, he is survived by one daughter, Mrs. Carey A. Stone, Jr., of Radford, Virginia; one son, Dr. Stephen B. Preston of Ann Arbor, Michigan; and four grandchildren.

* * * *

EDWIN O. VAUGHAN, M. D.

Dr. Edwin O. Vaughan, 67, of St. Albans, died on December 13 in a South Charleston hospital.

He was a native of Monroe County and was graduated from West Virginia University. He received his M. D. degree in 1928 from the Emory University School of Medicine.

Doctor Vaughan was licensed to practice in West Virginia in 1928 and was a resident of St. Albans for 35 years. At the time of his death he was a member of the St. Albans City Council.

He was a member of the Kanawha Medical Society, West Virginia State Medical Association and the American Medical Association.

He is survived by two sons, Edwin O. Vaughan, Jr., of St. Albans, and Dr. John W. Vaughan of Fayetteville, North Carolina; two daughters, Mrs. Mary B. Reed and Miss Ruth Vaughan of St. Albans; a brother, Dr. Dennis R. Vaughan of St. Albans; and a sister, Mrs. Lela Miller of Union, Monroe County.

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'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

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County Societies

EASTERN PANHANDLE

Dr. F. A. Hamilton, Jr., of Martinsburg, was reelected president of the Eastern Panhandle Medical Society at its regular monthly meeting which was held at the Shenandoah Hotel in Martinsburg on December 9.

Dr. William L. Rodgers was named first vice president, Dr. Daniel E. Hendricks second vice president, Dr. C. Vincent Townsend secretary-treasurer and Dr. J. L. Van Metre to the Board of Censors.

* * * *

HARRISON

Dr. Lawrence B. Thrush was the speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on December 3.

Doctor Thrush, who was introduced by Dr. A. Robert Marks, the president, presented a paper on "Some Aspects of Gastrointestinal Tract Surgery."

* * * *

KANAWHA

Dr. Edward Jackson of St. Albans was installed as president of the Kanawha Medical Society at a joint meeting with the Charleston Ministerial Association at the Daniel Boone Hotel on December 8. He succeeds Dr. George L. Grubb.

Dr. George R. Callender, Jr., was named vice president and Dr. Jerill D. Cavender secretary-treasurer, succeeding Dr. Henry R. Glass, Jr.

Doctor Glass was named to the Council along with Drs. Carl Roncaglione and Jay Emmett Rogers, Jr.

Dr. Norman A. Desrosiers, Medical Director of the North Carolina Alcoholic Rehabilitation Center at Butner, North Carolina, was the guest speaker.

Doctor Desrosiers is an ordained minister who became a hospital chaplain and grew so interested in medicine that he returned to school and received his M. D. degree. He called for teamwork on the part of physicians and clergy in giving long-term aid to families in which a member dies.

* * * *

McDOWELL

Dr. J. Hunter Smith was elected president of the McDowell County Medical Society at its regular monthly meeting which was held at Grace Hospital in Welch on November 18. He succeeds Dr. John S. Cook.

Dr. Charles F. McCord was named vice president, Dr. David J. Skewes, secretary, and Dr. Stephen Mamick, treasurer.

Drs. Freeman L. Johnston, Dante Castrodale and Guy E. Irvin were named to the Board of Censors Drs. A. J. Villani, J. Hunter Smith and David J. Skewes were selected as delegates to the 98th Annual Meeting of the West Virginia State Medical Association in August. Their alternates are Drs. Guy E. Irvin, R. H. Edwards and Charles F. McCord.—David J. Skewes, M. D., Secretary.

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Ascorbic acid (Vitamin C)	25 mg.
Prednisone	1 mg.

To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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BRIEF SUMMARY

Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

GREENBRIER VALLEY

Dr. Robert G. Shirey of Lewisburg was elected president of the Greenbrier Valley Medical Society at its regular monthly meeting which was held at The Greenbrier in White Sulphur Springs on December 9. He succeeds Dr. Harvey A. Martin of White Sulphur Springs.

Dr. Stuart T. Bray of White Sulphur Springs was named vice president and Dr. Claude L. Houck of Lewisburg, secretary-treasurer.

* * * *

HANCOCK

Dr. J. L. Thompson was elected president of the Hancock County Medical Society at its regular monthly meeting which was held at the Williams Country Club in Weirton on December 16.

Doctor Thompson succeeds Dr. David H. Williams. Other officers elected for the year were as follows:

Dr. Eli J. Weller, vice president, and Dr. George S. Kosar, secretary-treasurer.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Woman's Auxiliary

to the

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President Elect: Mrs. Wilson P. Smith, Huntington
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Second Vice President: Mrs. C. J. Holley, Wheeling
Third Vice President: Mrs. J. A. B. Holt, Charleston
Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William R. Rice, Dunbar.

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society sponsored a dessert bridge at the home of Dr. and Mrs. Richard K. Hanifan in Clarksburg on January 7. Benefits were contributed to the AMA-ERF.

Mrs. Hanifan, chairman of the AMA-ERF committee, was in charge of arrangements and she was assisted by Mesdames George W. Rose, Charles S. Harrison, Paul E. Gordon, E. Burl Randolph and Richard V. Lynch, Jr.

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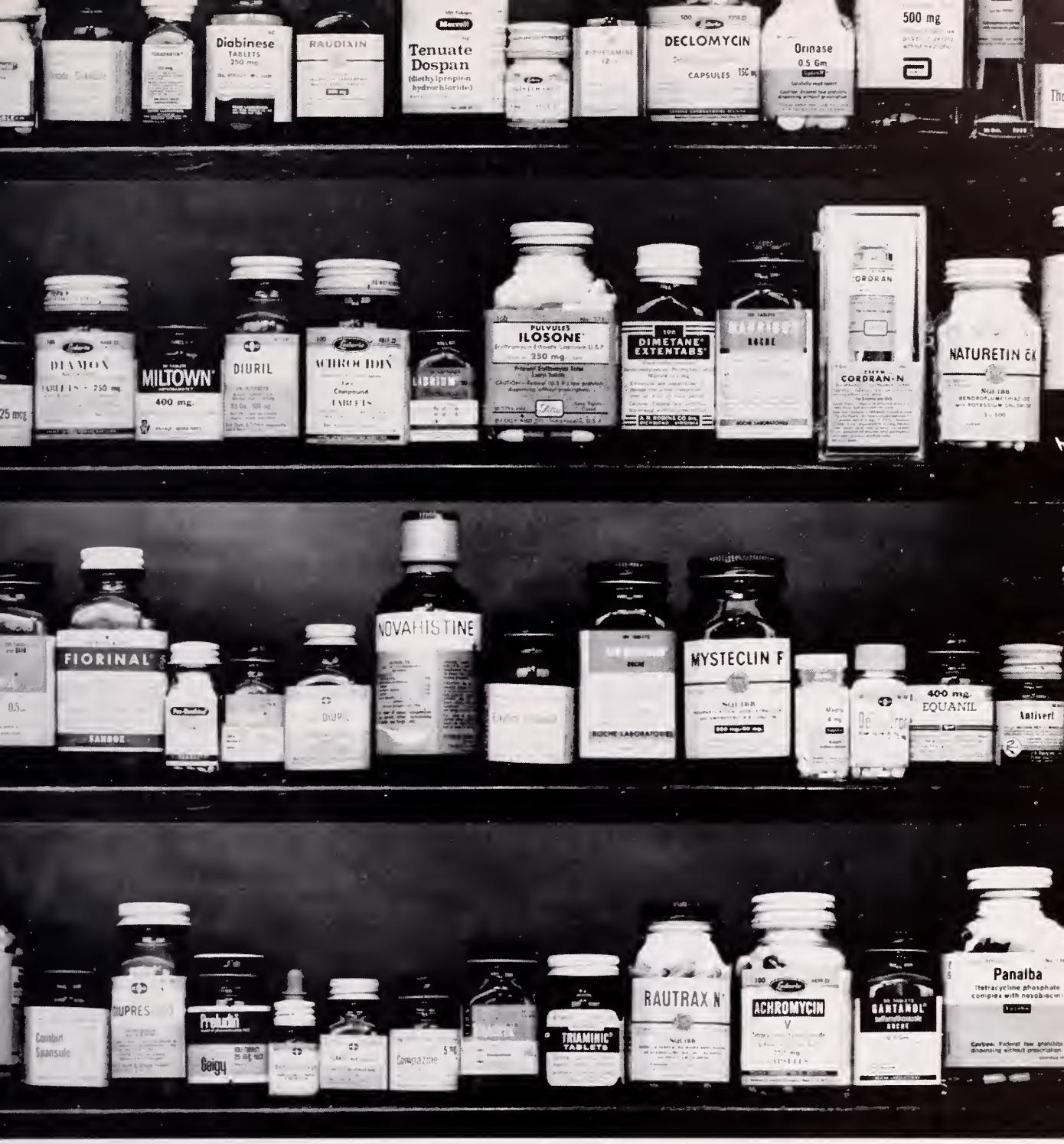

we couldn't begin to get them all into the picture . . .

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J. L. RITTMEYER, M. D.
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JOSIAH THOMPSON, M. D.
LUIS GUTIERREZ, M. D.

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Twenty-two members attended the function—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

MARION

Mrs. L. Rush Lambert was the speaker at the November dinner meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the Fairmont Hotel in Fairmont.

Mrs. Lambert, AMA-ERF Chairman, presented its background and accomplishments. She said that since 1952 the Auxiliary has contributed $1,863,000 toward removing the financial barrier to medicine.

Mrs. F. W. Mallamo, the president, presided at the business meeting. Reports were presented by Mrs. G. Thomas Evans, Mrs. David Bressler and Mrs. Rupert W. Powell.

Members of the Marion County Medical Society were entertained by the Woman's Auxiliary at a smorgasbord at the Fairmont Hotel in Fairmont on December 9.

Dr. and Mrs. Seigle W. Parks were honored for their 23 years of service to the Society and Auxiliary. They were presented with a silver tray.

Doctor Parks, a past president of the Marion County Medical Society and president elect of the West Virginia State Medical Association, recently was named Medical Director for the Chesapeake & Potomac Telephone Company of West Virginia.

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DAVID F. BELL, JR., M. D.
JOHN J. BRYAN, M. D.

ROENTGENOLOGY
S. G. DAVIDSON, M. D.

ANESTHESIOLOGY
DAVID H. GATHERUM, M. D.

BUSINESS MANAGER
JAMES L. FOSTER

RALEIGH

More than 280 members and guests attended the annual Christmas Dinner-Dance of the Raleigh County Medical Society which was held at the Black Knight Country Club in Beckley on December 11.

Dr. B. B. Richmond, the president, spoke briefly on the Society's successful Sabin Oral Polio program and the gift of its proceeds of $7,661.51, to the Beckley-Raleigh County YMCA Building Fund.

Mrs. Charles W. Merritt, president of the Woman's Auxiliary to the Raleigh County Medical Society, reviewed its program for the year.

Medical Meetings, 1965

The following is a partial list of national, state and district medical meetings scheduled for 1965:

March 26-27—National Rural Health Conference, Miami Beach.
Apr. 18-21—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Wheeling.
May 9-14—Ohio State Medical Assn., Columbus.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.

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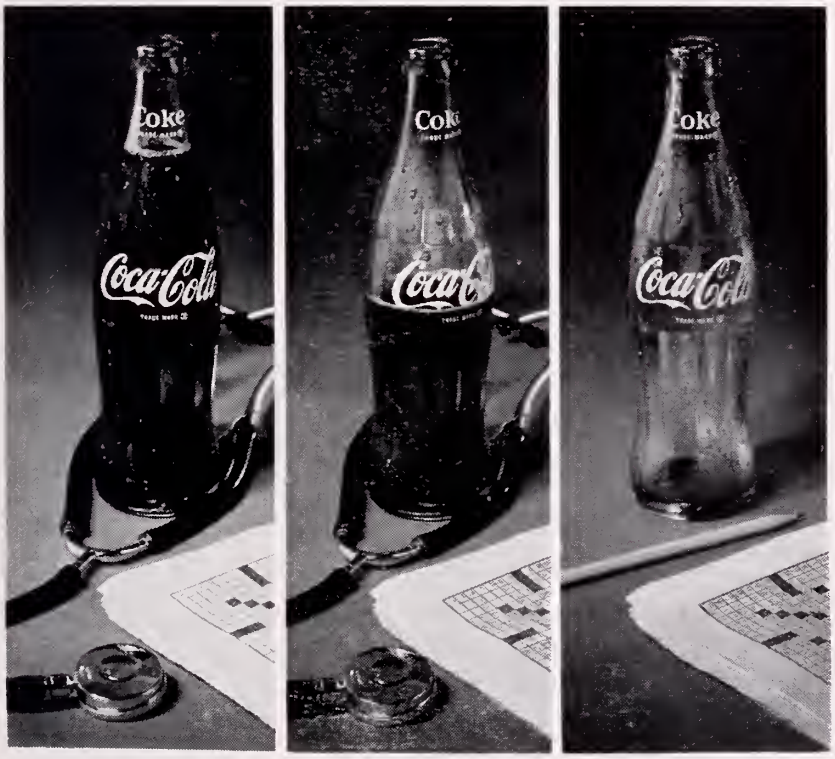

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Book Reviews

POLYPOID LESIONS OF THE GASTROINTESTINAL TRACT —By Claude E. Welch, M. D., Visiting Surgeon, Massachusetts General Hospital, Boston; and Clinical Professor of Surgery, Harvard Medical School, Boston. J. Englebert Dunphy, M. D., Consulting Editor. Pp. 148, with illustrations. Philadelphia and London: W. B. Saunders Company. Volume II in the Series, Major Problems in Clinical Surgery, 1964. Price $7.50.

This monograph, which happens to be Volume II in the Series of Major Problems in Clinical Surgery, updates prevailing attitudes of "Polypoid Lesions of the Gastrointestinal Tract" and their relationship to adenocarcinoma of the colon. Doctor Welch's viewpoints are based on an extensive personal experience at the Massachusetts General Hospital and he generously explains his attitudes pertaining to the many problems involved as well as comments pertaining to the management of such problems by other well qualified surgeons, in slightly less than 150 pages.

The topic "Polypoid Lesions of the Gastrointestinal Tract" is rather completely and fairly presented. The technique of satisfactory sigmoidoscopy with biopsy is commended to all to use in their practice. The minute details of more complicated surgical procedures are not presented in this volume. These of course can be found in larger surgical texts of which many are available.

The volume was a very pleasant review of this sometimes perplexing problem and it can be recommended for all physicians and surgeons who are likely to be involved in the care or diagnosis of "Polypoid Lesions of the Gastrointestinal Tract."—William E. Gilmore, M. D.

* * * *

CLINICAL NEUROLOGY—By Frank A. Elliott, M. D., F. R. C. P., Chief Neurology, The Pennsylvania Hospital, Professor of Clinical Neurology, University of Pennsylvania School of Medicine. Pp. 688. Illustrated. Philadelphia and London: W. B. Saunders Company. 1964. Price $12.50.

This volume, declared by the author to be an outline of clinical neurology intended for students and residents, is a very readable and usable book. It consists of 561 pages, 21 chapters, and eight pages of very adequate index. The author undoubtedly believes that a picture is worth many words for there are 171 figures consisting of line drawings, reproductions from other publications, and reproductions of photographs in black and white. These are well done and add greatly to the usefulness of the book.

One valuable feature is the admixture of anatomical and physiological explanation for neurological and clinical findings with the description of disease entities in various parts of the text, and these explanations seem to this reviewer a much easier way of learning neuroanatomy and physiology than by the more abstract manner in which they were taught during his training period.

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Although many neurological conditions are treated very briefly, the statements about them are concise and clear, and at the end of each chapter there is an extensive list of references providing the reader with ample information concerning sources and original writings. Although, as the author states in the preface, emphasis has been placed on the value of clinical methods, he has recorded several of the newer techniques in laboratory and mechanical diagnosis.

The glossy paper, printing, composition and structure of this volume is of the same high quality which has come to be expected of Saunders books, and the reviewer is glad to have it in his library.—E. Lyle Gage, M. D.

* * * *

CARDIAC ARREST AND RESUSCITATION—By Hugh E. Stephenson, Jr., B. S., M. D., F. A. C. S. Professor of Surgery, University of Missouri School of Medicine, Columbia, Mo. The C. V. Mosby Company; St. Louis. 1964. Pp. 410. Illustrated. Price $15.00.

This is an easy-to-read book that furnishes quite fascinating reading for any physician or resident physician that has been faced or may be faced with "sudden death." This book covers in sequence the precipitating cause of arrest, diagnosis, and management of cardiac arrest, and then discusses the prevention. All modern methods are covered under treatment including that of arrhythmias. Practically all the unusual questions that have arisen over the years with the increased knowledge concerning cardiac arrest are answered somewhere in this volume.

There is an excellent chapter on prevention of cardiac arrest which also answers practically any question that may arise in the various specialties, in altered body chemistry, or in the various diseases.

The final chapter discusses neurological sequela and gives a good summary of present date knowledge of brain damage under different degrees of anoxia and various other important conditions.

Much information has been accumulated in this book. It is well worth the time spent in reading it.—Morris H. O'Dell, M. D.

Books Received

RESPIRATORY FUNCTION IN DISEASE (An Introduction to the Integrated Study of the Lung)—By David 1. Bates, M. D. (Cantab.), M.R.C.P. (London), Associate Professor of Medicine, McGill University; Director, Respiratory Division, Joint Cardiorespiratory Service, Royal Victoria Hospital and Montreal Children's Hospital; and Ronald V. Christie, M. D. (Edinburgh), M.Sc. (McGill), D.Sc. (London), Sc.D. (Dublin), F.A.C.P., F.R.C.P. (London), F.R.C.P. (C), Professor and Chairman of the Department of Medicine, McGill University; and Physician-in-Chief, Royal Victoria Hospital. Pp. 566 with illustrations. Philadelphia and London: W. B. Saunders Company. 1964. Price $15.50.

* * * *

PEDIATRIC PROCEDURES—By Walter T. Hughes, Jr., M. D., Assistant Professor of Pediatrics, University of Louisville School of Medicine, Louisville, Kentucky. Philadelphia and London: W. B. Saunders Company. Pp. 208. Illustrated. 1964. Price $7.50.

* * * *

SCINTILLATION SCANNING IN CLINICAL MEDICINE—By James L. Quinn, III, M. D., Editor, Assistant Professor of Radiology, Northwestern University School of Medicine; Director of Nuclear Medicine, Chicago Wesley Memorial Hospital. Formerly Chief, Nuclear Medicine Service, The Bowman Gray School of Medicine. Pp. 278. Illustrated. Philadelphia and London: W. B. Saunders Company. 1964. Price $11.50.

* * * *

EXPERIENCE IN RENAL TRANSPLANTATION — By Thomas E. Starzl, Ph.D., M. D., Professor of Surgery, University of Colorado School of Medicine; Chief, Surgical Service, Veterans Administration Hospital, Denver, Colorado. Pp. 383, with illustrations. Philadelphia and London: W. B. Saunders Company. 1964. Price $17.00.

* * * *

COMMON BACTERIAL INFECTIONS—By Edwin J. Pulaski, Col., M. C., U. S. Army, Director, Division of Basic Research, Institute of Research, Walter Reed Army Medical Center, Washington, D. C. Pp. 301. Illustrated. Philadelphia and London: W. B. Saunders Company. 1964. Price $8.50.

* * * *

BRAIN-THYROID RELATIONSHIPS—By Margaret P. Cameron, M. A., and Maeve O'Connor, B. A.; Little, Brown, and Company, Boston. 1964. Pp. 117. Illustrated. Price $1.95.

* * * *

CELLULAR INJURY—Edited by A. V. S. DeReuck, M. Sc. D. I. C., A. R. C. S. and Julie Knight, B. A.; Little, Brown and Company, Boston. Pp. 403. Illustrations—81. 1964. Price $12.00.

* * * *

HANDBOOK OF OBSTETRICS & GYNECOLOGY—By Ralph C. Benson, M. D., Professor of Obstetrics and Gynecology and Chairman, Department of Obstetrics and Gynecology, University of Oregon Medical School, Hospitals and Clinic, Portland, Oregon. Lange Medical Publications, Los Altos, California. Pp. 657. Illustrated. Price $5.00.

* * * *

EMERGENCY TREATMENT AND MANAGEMENT—By Thos. Flint, Jr., M. D., Associate Physician, Kaiser Foundation Rehabilitation Center and Senior Consultant, Emergency Department and Division of Industrial Relations, Kaiser Foundation Hospital. Pp. 686. Illustrated. W. B. Saunders Company, Philadelphia, London. 1964. Price $8.75.

* * * *

A MARRIAGE MANUAL FOR CATHOLICS—By William A. Lynch, M. D., Trident Press, New York. Pp. 359. 1964. Price $4.95.

* * * *

ANIMAL BEHAVIOR AND DRUG ACTION—By Hannah Steinbert, Ph. D.; A. V. S. DeReuck, M. Sc., D. I. C., and Julie Knight, B. A. Pp. 490. Illustrated. Little, Brown, and Company, Boston. 1964. Price $13.00.

* * * *

TEXTBOOK OF PEDIATRICS—Edited by Waldo E. Nelson, M. D., D. Sc., Professor of Pediatrics, Temple University School of Medicine and Woman's Medical College of Pennsylvania; Attending Pediatrician, Saint Christopher's Hospital for Children. Pp. 1636. W. B. Saunders Company, Philadelphia. 1964. Price $18.00.

* * * *

CLINICAL NEUROLOGY—By Frank A. Elliott, M. D. F. R. C. P., Chief of Neurology, The Pennsylvania Hospital, Professor of Clinical Neurology, University of Pennsylvania School of Medicine. Pp. 688. Illustrated. W. B. Saunders Company, Philadelphia, London. 1964. Price $12.50.

* * * *

CONTROL OF GLYCOGEN METABOLISM—By W. J. Whelan, Ph. D., D. Sc., F. R. I. C. and Margaret P. Cameron, M. A.; Little Brown and Company, Boston. 1964. Pp. 434. Illustrations—72. Price $12.50.

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As the evidence piled up, the Society intensified its public educational efforts, with teen-agers the specific target. Many private and government agencies were stimulated to take action.

But people have short memories. Already the message of the Surgeon-General's report has been blurred with the passage of time. Unless those with the responsibility for protecting health act vigorously, the public will continue to lose sight of the risk . . . and smoke cigarettes.

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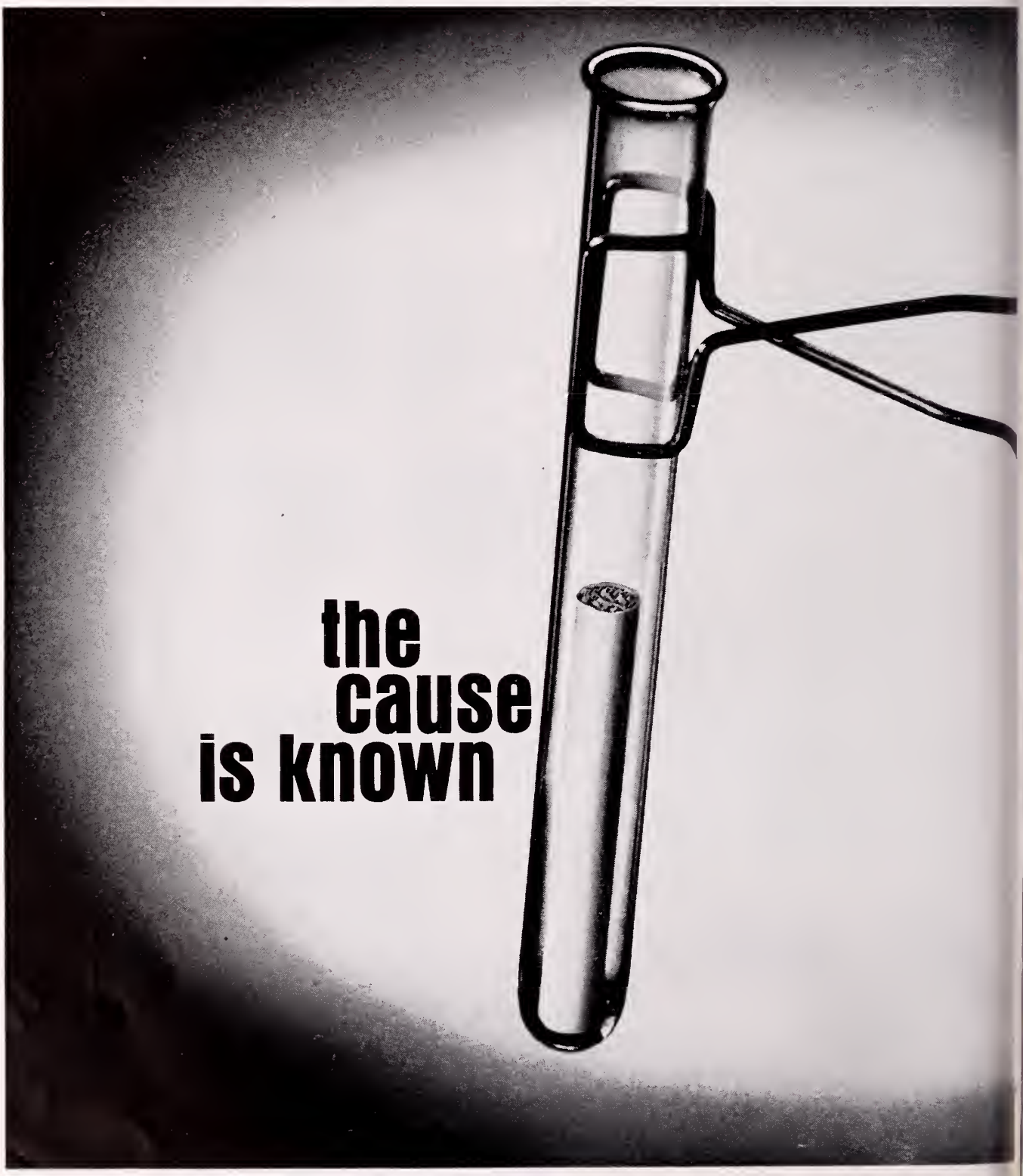

The West Virginia Medical Journal

March, 1965 Vol. 61, No. 3

Meigs' Syndrome: Report of a Case and Review of the Literature

Sion Soleymani, M. D., and Raymond W. Cronlund, M. D.

Meigs and Cass, in 1937, reported seven cases of fibroma of the ovary associated with ascites and hydrothorax in which spontaneous disappearance of the fluid in the abdominal and thoracic cavities occurred following removal of the fibroma. The syndrome is rare, yet is of considerable interest from the general clinical aspect. Recognition of the disease entity is important, since Meigs' syndrome is curable if diagnosed and the patient operated upon in time. No solid ovarian tumor with peritoneal and chest fluid ever should be allowed to be delegated to the category of inoperable malignancy without the benefit of a definite tissue diagnosis. Operation is mandatory in all such cases. Cullingworth, who is often credited with the first description of the syndrome, reported a case in 1879 in which the patient died of the disease.

The particular triad of findings was first called "Meigs' syndrome" by Rhoads and Terrell, in their report published in 1937.

Meigs' 1937 report, however, was not the first to appear on this subject. Spiegelberg, in 1866, first reported a case which was discovered at post mortem examination.

In an extensive review of the literature, Meigs, in 1954, re-defined the syndrome as being limited to cases either with fibroma of the ovary, thecoma, granulosa cell tumor, or Brenner tumor, ascites, hydrothorax, and cure, following removal of the tumor.

In the same year Meigs reviewed the literature and accepted 84 cases as meeting the criteria of the syndrome. Seventy-nine patients had no recurrence after operation; four died without operation, and one succumbed to an intercurrent disease. These 84 cases comprised all the English language literature and some cases reported in other languages. Since 1954, reported cases have been few.

Submitted to the Publication Committee, July 31, 1964.

The Authors

- **Sion Soleymani, M. D., and Raymond W. Cronlund, M. D., Broaddus Hospital, Philippi, West Virginia.**

The patient's age in all cases published has ranged from 9 to 75 years.

Syndrome's Most Common Cause

It must be remembered that any type of ovarian lesion may produce ascites and hydrothorax. It has been reported that fibroma and fibroma-like tumors of the ovary are by far the most common cause of this syndrome. Demons, in 1887, reported nine cases of cysts of the ovary in which ascites and hydrothorax were cured by removal of the cysts. These patients, according to present day concepts, did not have Meigs' syndrome but pseudo-Meigs' syndrome, since in true Meig's syndrome the tumor must be a fibroma or a fibroma-like tumor. All other pelvic tumors associated with ascites and hydrothorax that clear by removal of the tumor are now called "pseudo-Meigs' syndrome." In pseudo-Meigs' syndrome, relief from the fluid occurs but a cure does not always follow. Some authors believe that all pelvic tumors, benign or malignant, solid or cystic, associated with ascites and hydrothorax that clear after removal of the tumor should be called Meigs' syndrome. Ascites and hydrothorax, however, are found more commonly with fibroma than other pelvic tumors. Ovarian fibroma repre-

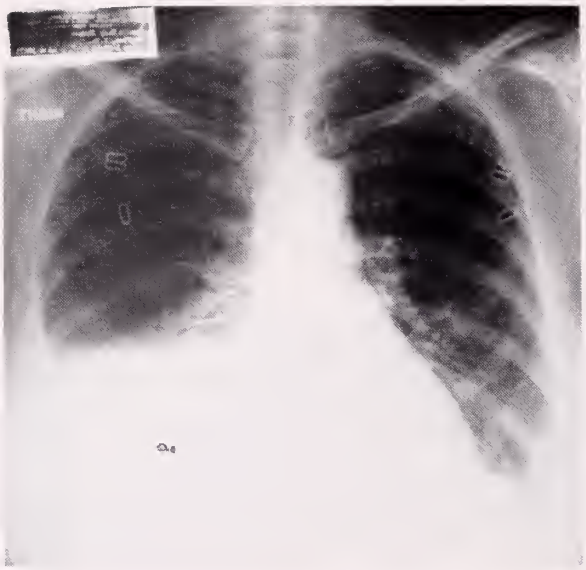

Figure 1. Roentgenogram of chest revealing right pleural effusion.

sents 2 to 5 per cent of all ovarian tumors. Less than 20 per cent are associated with ascites and of these less than 1 per cent with hydrothorax.

Cause of Ascites

Cause of the ascites has remained a controversial subject. The most accepted theory is that it transudes from the ovarion growth into the peritoneal cavity and into the chest via transdiaphragmatic channels. Numerous investigators have reported that most fibromas associated with Meigs' syndrome show microscopic evidence of edema. The edema within the tumor probably is best explained by the pressure of the firm tumor on the efferent blood and lymphatic vessels in the pedicle or hilum of the ovary. Ascites may occur in varying quantity irrespective of the size of the tumor. Sometimes the ascites may be so negligible as to escape notice or to be not definitely determined in the clinical examination while, at the same time, pleural fluid is present in large quantities.

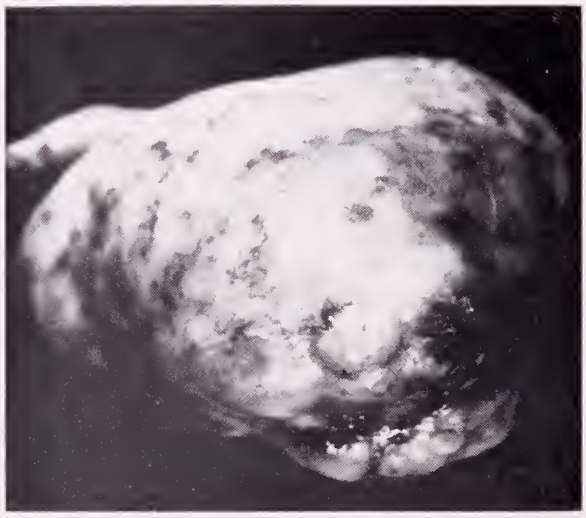

Figure 2. Gross appearance of excised right ovarian tumor. Mass was oval-shaped, nodular, solid, measuring 17x11x9 cm.

Hydrothorax occurs in the right chest in 75 per cent of cases, in the left chest in 10 per cent, and bilaterally in 15 per cent. The fluid is a transudate; cases have been reported, however, in which the fluid was bloody and the specific gravity was as high as 1.040. The fluid may show few to many white blood cells which, when present, usually are lymphocytes. The mechanism of its formation is not definitely known. Meigs and others have shown, with the use of electrophoretic protein determination, that the chest and the abdominal fluids are the same. It was demonstrated by means of India ink injection that the passage of fluid is from the abdomen to the chest and not the reverse. One case has been reported, however, in which the pleural effusion moved from the right chest to the abdomen and back to the pleural cavity. This has been proved by clinical evaluation and x-ray study. Meigs has discussed the possibility of the fluid passing through a congenitally patent foramen of Bochdalek's or other congenital diaphragmatic opening. These foramina, if large enough, would allow the fluid to move back and forth.

Differential Diagnosis

If this syndrome is not kept in mind, great difficulty might be encountered in differential diagnosis. The later stages are chiefly suggestive of a malignant tumor with metastasis. Several cases in which, for six months or a year, the patients have been treated by repeated paracentesis and thoracentesis on grounds of supposed malignancy are described in the literature. In one supposedly hopeless case, altogether 850 liters of ascitic fluid, including large quantities of pleural exudate, were removed over a period of three years. The patient was, of course, an invalid. But since she never became cachectic in the ordinary sense, doubts arose concerning the malignancy and finally she was laparotomized. Nothing was found but a benign ovarian tumor which was easily removed, and the patient was restored to full health within the course of a month.

At early stages of the syndrome when the tumor is small and hydrothorax may be the dominant symptom, it often has been diagnosed as pleurisy or tuberculous polyserositis and the patient placed in a sanatorium or treated for tuberculous pleurisy.

Signs and symptoms of Meigs' syndrome are generally typical:

1. There is a solid tumor apparently arising from the pelvis.

2. Ascites and hydrothorax are present with resultant symptoms. Dyspnea, chest pain, cough, weakness, poor appetite, edema of the legs, neck vein distention, mediastinal shift, hepatomegaly, incontinence, frequency of urination, abnormal uterine bleeding of all types, have been reported.

3. Chest x-ray substantiates the presence of fluid.

4. The condition usually is post-menopausal and is unaffected by marital status or parity.

5. Before removal of the tumor, fluid will recur after paracentesis; after removal of the tumor, fluid disappears in 3 to 14 days and will not recur.

6. Removal of the tumor is followed by prompt recovery from all symptoms.

7. The clinical course is afebrile.

Case Report

A 61-year-old waitress, white, single, was seen with the chief complaint of cough and moderate shortness of breath of 3 weeks' duration. The cough had been constant and gradually had increased in severity during the 3-week period.

Three months before onset of the cough, the patient had a routine chest x-ray taken by mobile x-ray unit, and was told that she had some fluid accumulation in the right chest. She had been asymptomatic, however, and did not pay any particular attention to this until recent episodes of constant cough. She had no chest pain, no hemoptysis, and no night sweats nor fever. Two weeks prior to admission, she had noticed moderate edema of the ankles.

Past medical history revealed no previous operations or serious illnesses except for scarlet fever in childhood, with subsequent partial hearing loss. Her general health had been good and her usual weight had been 150 pounds.

Physical examination revealed the patient to be well developed and well nourished. Height 64 inches. Weight 170 pounds. Temperature 98 F. Pulse 90 per minute. Respiratory rate 18. Blood pressure 160/90. Skin warm and moist. Peripheral pulses palpable, equal, and of good quality.

Examination of the neck revealed no palpable nodes, and the thyroid was not enlarged. The chest was symmetrical, hyper-resonant to percussion on the left and dull to percussion over the right lower lung field. There was absence of breath sounds on the right; the left lung was clear to auscultation. Heart sounds were normal; no murmurs were present. There was no evidence of increase in cardiac size.

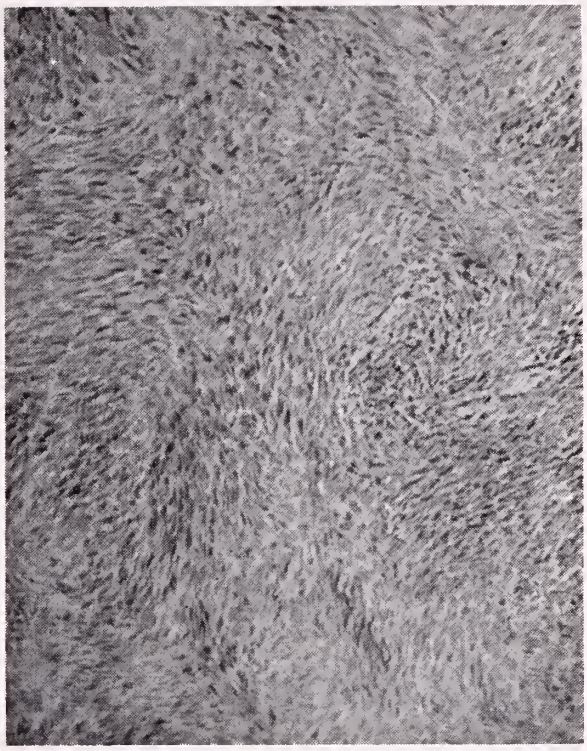

Figure 3. Solid fibroma of right ovary with characteristic interlacing bundles of spindle cells. Hematoxylin—Eosin.

The abdomen was round, soft, and nontender. Suggestion of a fluid wave was present. One of the examiners was of the opinion that ascites was definitely present. The liver, kidneys, and spleen were not palpable. There was a firm, nontender, nodular mass, irregular in outline, in the lower abdomen more to the right side. Pelvic examination revealed the following: vulva normal; vagina moderately relaxed; cervix edematous, clear, and nontender. The uterus appeared to be irregularly enlarged and displaced to the right. The right adnexa were difficult to delineate. The left adnexa revealed no abnormality. Rectal examination confirmed the presence of a palpable pelvic mass. There was moderate edema of the lower legs.

No abnormalities were observed on neurologic examination.

The clinical impression at this time was either Meigs' syndrome or myofibroma uteri.

Laboratory studies revealed hemoglobin content to be 12 Gm. per 100 cc. of blood; red blood count 4,600; while blood count 8,000 per cubic mm. with cell differential within normal limits. Sedimentation rate was 84 mm. in 1 hour. Urin-

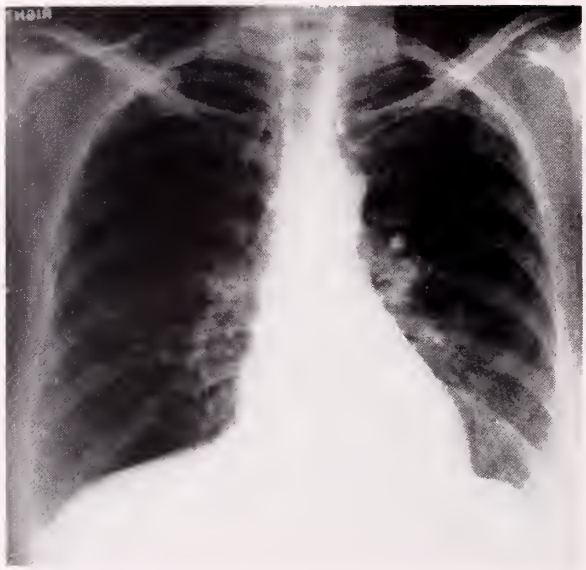

Figure 4. Follow-up roenigenogram revealing complete disappearance of pleural effusion of right chest.

alysis revealed negative sugar; 3+ albuminuria; 50-150 white blood cells; 10-25 red blood cells. Urine culture showed no growth in 48 hours. Total serum proteins 5.9 Gm. per 100 cc.; albumin 4.0 Gm. per 100 cc.; globulin 1.9 Gm. per 100 cc.; A/G ratio 2. 1 : 1. Blood sugar and blood urea nitrogen were within normal limits. EKG was normal except for low voltage which was thought to be due to systemic or metabolic disease. VDRL and RPCF were nonreactive. Sputum studies for acid fast bacilli were negative.

Chest x-ray revealed pleural effusion of right thorax (Figure 1). Intravenous pyelogram revealed a normal urinary system bilaterally, with slight mobility of the right kidney of no clinical significance. A flat plate of the abdomen revealed no evidence of introperitoneal calcification.

Hospital Course.—On admission, thoraecentesis of the right chest was performed and 1,600 cc. of clear, yellowish fluid removed. Cytologic examination of the fluid was negative for malignant cells; the fluid was reported to be a transudate. Culture revealed no growth in 48 hours.

At operation, dilatation and curettage were performed prior to the abdominal surgery. The endometrium was normal.

Exploratory laparotomy was performed under general anesthesia. The peritoneal cavity was entered through a subumbilical midline incision. Clear, yellowish, intraperitoneal fluid was present. A right ovarian tumor, oval-shaped, nodular and solid, measuring 17 x 11 x 9 cm. was found (Figure 2). The tumor appeared to be completely encapsulated. There were some adhesions about the left ovary; the uterus was small. There were no other abnormal findings. Bilateral salpingo-oophorectomy was performed. The right ovarian tumor was reported to be a solid fibroma consisting of interlacing bundles of spindle cells with relatively large, elongated nuclei and collagenous material; edema was noted in some areas so that the tumor cells were separated (Figure 3). The tumor cells were well differentiated and presented no evidence of atypical change. One section showed ovarian tissue with a large corpus albicans.

The postoperative course was uneventful. The abdomen remained soft and the wound healed well. The patient's general condition improved. A follow-up chest x-ray revealed complete disappearance of the pleural effusion of the right chest (Figure 4).

Urinalysis still revealed 2+ to 3+ albuminuria.

The patient was discharged in satisfactory condition and is being followed in our outpatient clinic.

References

1. Ainslie, W. H. & Akey, D. T.: Meigs' Syndrome, J. M. Soc. New Jersey 54:56, 1957.
2. Anderson, H. B.: Malignant Cystadenoma of Ovary With Pleural Effusion (Meigs' Syndrome), Pennsylvania M. J. 47:671, 1944.
3. Arban, A. J.: The Pseudo-Meigs' Syndrome. Report of A Case. J. South Carolina M. A. 57:8, 1961.
4. Blair, R. G.: Case of Meigs' Syndrome—An Incomplete Form With Multiple Pelvic Pathology, J. Obst. & Gynaec. Brit. Emp. 68:1046, 1961.
5. Budicin, J. C. & Marine, W. C., Jr.: Meigs' Syndrome. Report of a Typical Case. California & West. Med. 96:277, 1962.
6. Caffrey, J. A. & Fellows, J. G.: Meigs' Syndrome. Report of One Case. J. Iowa M. Soc. 49:347, 1957.
7. Cowan, I. I., Cron, R. S., Burgess, C. F. & Karioris, F. G.: Transport of Radioactive Colloidal Gold Between Serous Cavities, Surg., Gynec. & Obst. 98:721, 1954.
8. Johnson, W. S., Gale, J. C. & Smith, C. D.: Benign Tumors of the Ovaries Associated With Fluid in the Chest. Case Report. Virginia M. Monthly 84:569, 1957.
9. Justen, J. W.: Meigs' Syndrome. Case Report. Am. J. Obst. & Gynec. 78:830, 1959.
10. Knuth, W. P. & Walske, B. R.: Malignant Ovarian Tumor With Ascites and Hydrothorax Simulating Meigs' Syndrome, Am. J. Surg. 95:480, 1958.
11. Meigs, J. V.: Fibroma of Ovary With Ascites and Hydrothorax—Meigs' Syndrome, Obst. & Gynec. 67:962, 1954.
12. Meigs, J. V.: Fibroma of Ovary With Ascites and Hydrothorax—Meigs' Syndrome, and Other Pelvic Tumors With Ascites and Hydrothorax—Pseudo-Meigs' Syndrome, Progr. Gynec. 3:424, 1957.
13. Meigs, J. V.: Pelvic Tumors Other Than Fibroma of Ovary, With Ascites and Hydrothorax, Obst. & Gynec. 3:471, 1954.

14. Meigs, J. V. & Cass, J. W.: Fibroma of Ovary With Ascites and Hydrothorax, Am. J. Obst. & Gynec. 33:249, 1937.
15. Mokrohisky, J. F.: So-Called Meigs' Syndrome Associated With Benign and Malignant Ovarian Tumors, Radiology 70:578, 1958.
16. Norris, S. & Chesnie, J. J.: Meigs' Syndrome, With Report of a Case, Canad. M. A. J. 79:397, 1958.
17. Parker, R. B.: Letters to the Editor. Meigs' Syndrome. Lancet 2:242, 1954.
18. Reiss, H. E.: Case of Ovarian Fibroma and Meigs' Syndrome, Brit. M. J. 5237:1440, 1961.
19. Schnur, L., Brilkart, K. B. & Schnur, P.: Meigs' Syndrome. Report of a Case and Review of the Literature, Arizona Med. 19:202, 1962.
20. Stephanopolous, C. & Doucas, N.: Meigs' Syndrome. Report of an Unusual Case. Brit. J. Dis. Chest 56:96, 1962.
21. Stoll, G. F.: Hydrothorax Associated With Ovarian Carcinoma Simulating Meigs' Syndrome. Report of 2 Cases. J. M. Soc. New Jersey 59:471, 1962.
22. Thomson, E. L.: A Case of Meigs' Syndrome, Brit. M. J. 5189:1866, 1960.

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Gastrointestinal Allergy*

Maurice Kaufmann, M. D.

About 1000 B. C. Lucretius said, "What is food to one may be fierce poison to another." Although other allergens can cause, contribute to, or aggravate gastrointestinal symptoms, foods, and to a lesser extent drugs, are the most common causes of gastrointestinal allergy.

Opinion varies widely as to the role allergy plays in manifestations of the gastrointestinal tract. Perhaps this is the result of insufficient and inadequate study of the digestive system. It is extremely difficult to carry out food tests objectively and it is moderately difficult as well as inconvenient to observe the direct effect of food on the mucous membrane and the gastrointestinal tract, either endoscopically or radiologically. Many of the changes in the gastrointestinal tract occur in an evanescent or temporary manner as these alterations usually are reversible. The mucous membrane, however, is comparable in some ways to the skin and direct visualization, if practical, would be more informative. Lastly, many gastrointestinal symptoms may be due to irritation, idiosyncrasy and toxicity, in addition to specific hypersensitivity or atopy.

Incidence

Statistics regarding the incidence of allergy vary considerably, probably as a result of the difference in the degree of interest shown these disorders by the internist, the pediatrician, the gastroenterologist and the allergist. Except for those instances in which the patient presents himself with complaints attributed to the digestive system, symptoms referable to the gastrointestinal tract often are overlooked unless the patient is questioned about such symptoms. In persons who have other allergies, inquiries often will elicit a past or present history of digestive tract symptoms which are considered allergic. Infants and young children have the highest incidence of gastrointestinal allergy, probably due to the "immaturity" of the gut wall. This frequently permits the passage of unsplit proteins through the intestinal mucosa.

*Presented before the Seventh Annual Meeting of the West Virginia State Society of Allergy, held during the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, 1964.

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Etiology

The mechanism in gastrointestinal allergy is similar in effect to the tissue response of other allergic shock organs. The reaction may appear at any site or at several locations along the course of the gastrointestinal tract, beginning at the lips and ending at the anus.

Why the mucous membrane of the digestive tract is susceptible to allergic trauma should not be difficult to understand when one considers the numerous and variable allergenic stimuli to which this tissue is exposed.

Foods head the list as the most common cause of gastrointestinal allergy, with drugs, inhalants, injectants and nonspecific factors next in order. Foods customarily eaten should always be suspected, and these include milk, eggs and wheat. Other foods commonly at fault are nuts, chocolate, fish (especially shell fish), tomatoes, strawberries, spices and fresh fruits and vegetables in season. It should be remembered, however, that any food can cause symptoms in the susceptible person.

Although drugs are less frequent offenders when compared with foods, they nevertheless can cause violent and serious symptoms such as angio-edema or diarrhea. The difficulty in ascribing gastrointestinal reactions to drugs lies in the differentiation between allergic, toxic or intolerance effect. Glossitis, stomatitis, gastritis and colitis probably are the most common clinical manifestations of drugs in the gastrointestinal tract.

Inhalants for the most part contribute to gastrointestinal symptoms indirectly, with the gastrointestinal tract acting as a secondary target tissue in a person with an allergic predisposition and with other allergic diseases. An example of such a cross-sensitization is seen in the person with "rose fever" and colitis who is cereal sensitive. During the grass pollination season he

cannot tolerate wheat because wheat aggravates the rhinitis as well as intensifies the colitis.

Injectants are known to cause or aggravate allergic gastroenteritis. Included among injectants is the sting of the hymenoptera insect. Injected vitamins, hormones, antibiotics and foreign sera may produce symptoms such as abdominal cramps, nausea and vomiting.

Response of the gastrointestinal tract to nonspecific factors is mediated through the autonomic nervous system. The effect on the gastrointestinal system of emotional and stress situations is well documented. Some reactions are the result of physical or irritant stimuli such as drinking very cold beverages or eating highly seasoned foods. The seasonal variations referred to earlier are not unusual in allergic persons with pollen and food sensitivity. Numerous examples of other nonspecific agents causing abdominal discomfort, nausea, vomiting and diarrhea are commonly observed in clinical practice.

Pathology

In most instances of gastrointestinal allergy it is difficult to obtain and demonstrate pathological evidence or specimens. Patients very seldom die of allergy *per se* except in cases of anaphylactic shock, bronchial asthma, or one of the collagen diseases. Anatomic changes in the digestive tract from allergy usually are reversible; the clinical picture is evanescent and direct examination, except for the oral cavity and rectum, is difficult and not routinely done. The gross picture is hyperemia, swelling, muscle spasm and increased mucus. Histologic changes are edema, serious exudation, eosinophilic infiltration and vascular changes.,

Clinical Manifestations

Many conditions listed in Table 1 may or may not be allergic or atopic in so far as antigen-antibody reaction can be demonstrated. Clinically, at least, often no other explanation can be offered for the occurrence or periodic recurrence of these manifestations except on some hypersensitivity basis, particularly if a cause and effect relationship exists. It is partially for this reason that the symptoms and manifestations are listed as "probable" and "possible" gastrointestinal allergy.

Diagnosis

The possibility and probability of allergy contributing to gastrointestinal symptoms should be suspected when other allergic syndromes such as eczema, urticaria, hay fever or bronchial asthma are present. The diagnosis of allergy due to food is readily made when certain foods can produce or reproduce gastrointestinal symptoms whenever they are eaten. When digestive disturbances occur seasonally, the possibility of allergy as a causative factor suggests itself. Prolonged or recurrent gastrointestinal manifestations without any other demonstrable cause should always alert the clinician to the possibility of allergy as a cause. In order to elicit and interpret these and other factors, a history of all details is mandatory.

Other considerations which suggest an allergic etiology include the development of symptoms shortly after the ingestion of food or within 24 hours. Recurrent and frequent ulcerative stomatitis (canker sores) is a common finding; other vague but suspicious signs of allergic gastroenteritis include excessive salivation, unexplained nausea, bloating or distention after meals, colicky pains and cramps, episodes of explosive diarrhea, alternating diarrhea with constipation, and pruritus ani. A diary kept by the patient recording his diet, medications or activities in relation to the onset and development of signs and symptoms, often aids in pinpointing the source of trouble.

Table 1

Clinical Manifestations

Probable G. I. Allergy

1. Cheilitis and perleche often due to contact with foods such as citrus fruits and to other contactants such as lipstick and toothpaste.
2. Canker sores (aphthous stomatitis) often from chocolate, nuts or "acid" foods but viral disease may play a role.
3. Glossitis and geographic tongue.
4. Gingivitis.
5. Cardiospasm—"acid indigestion."
6. Colic and pylorospasm in infants.
7. Cyclic or recurrent nausea and vomiting with or without abdominal pain.
8. Vague indigestion syndromes with recurrent cramps, pain, bloating, distention or unexplained nausea.
9. Certain intestinal disorders affecting the small or large bowel, or both, as: mucous colitis, irritable or spastic colon, unexplained diarrhea, spastic constipation.
10. Some cases of pruritus ani.
11. Henoch's purpura.

Possible G. I. Allergy

1. Certain recurrent disorders, so-called periodic disease with eosinophilia.
2. Sialorrhea and parotid swellings.
3. Ulcer-like sydromes.
4. Certain gallbladder syndromes without stones, poor function cases not relieved by operation.
5. Ulcerative colitis.
6. Appendalgia.
7. Abdominal migraine.
8. Regional enteritis (Crohn's disease).
9. Celiac syndrome.
10. Anorexia and malnutrition.

Objective confirmatory diagnostic signs are disappointingly few. In the absence of parasites, the presence of eosinophilia in the blood or stools (mucus) is very suggestive. Radiologic studies of the digestive tract can be informative, especially when the suspected food is disguised in the barium mixture. The findings include increased motility, spasm, segmentation and decrease in the lumen, particularly that of the small bowel.

Allergy skin tests are helpful in a fair percentage of cases. Although skin tests with foods may not be as specific or dependable as pollen, they are of considerable value in persons with an exquisite sensitivity to food such as egg, shellfish or cottonseed. Skin tests with unadulterated foods probably would be more reliable if this method were more practical. Positive reaction to other allergens in a person with suspected gastrointestinal allergy is also significant, at least in establishing the existence of the atopic constitution.

The differential diagnosis between gastrointestinal allergy and other diseases of the digestive tract requires a wide knowledge of gastroenterology. The role of allergy in the production of gastrointestinal symptoms often is decided after the exclusion of other common digestive disorders and this demands a complete history, physical examination, endoscopy, x-ray studies, gastric and stool analysis and other indicated studies and tests.

Therapy

Treatment can be divided into prophylactic (dietary) and symptomatic. The preventive measures, at least in so far as foods are concerned, are readily applicable to infants and children. If there is a strong family history of allergy it usually is wise to start the infant on hypo-allergenic foods and a milk substitute if not nursing breast milk. In the older infant and child with other allergies such as eczema, urticaria or bronchial asthma, the overindulgence in common allergenic foods should be avoided. Specific food offenders must be completely eliminated until definite improvement is maintained. At this point, a trial with small portions of the offending food can be given but it must be immediately discontinued should it exacerbate symptoms. If the diet is adequate without the offending food, there is no hurry in returning it to the diet because the longer it is eliminated, the greater the likelihood of losing sensitivity to this allergen.

When other allergies coexist in the same person, especially in an individual with seasonal occurrence or exacerbations such as hay fever or pollen asthma, it may only be necessary to omit the specific food offenders during the particular season. This rule applies regardless of whether the food aggravates the gastrointestinal, respiratory or skin manifestations. Apropos to this, it should be remembered that the situation may be reversed, i. e., the gastrointestinal symptoms are worsened while the patient is having urticaria, hay fever or asthma. In this regard, adequate treatment and control of these other allergic syndromes by conventional hypo-allergic management will lessen the incidence and degree of related gastrointestinal disturbances.

When specific food offenders cannot be pinpointed for whatever reason, other dietary measures, including the use of special elimination diets, can be employed. Some of the more familiar elimination diets are Rowe's, Andresen's and Rinkel's rotation diets. Each of these authors approaches the problem somewhat differently but the end result is the determination of a diet which does not induce or aggravate symptoms.

The immediate relief of symptoms often is more pressing than determining the cause, and until the latter is ascertained, symptomatic measures must be employed. Of course, the elimination of the allergen will bring about relief but even this may require a few weeks, assuming that the particular allergic agent has been identified. The allergenic effect of a food may take several weeks to disappear, depending upon the nature of the disease and how completely the food is avoided. It is important to know that some foods are present in many forms and mixtures other than their natural state. Also the cross-relationship of some foods with inhalant sources, for example, cereal grains with grasses, should be borne in mind in treating persons with combined sensitiveness.

Theoretically, at least, antihistamines should relieve gastrointestinal allergies, but the results with these drugs are somewhat disappointing. That is not to say that they should not be given a trial. Those antihistamines with a sedative side-effect are perhaps somewhat more efficacious, possibly through spasmolysis. The antihistamines also help counteract associated allergies or reduce the general allergic reactivity. When other indicated medications such as demulcents, antispasmodic, anti-emetic and antidiarrheal preparations are used in conjunction with antihistamines, the results often are superior to those in cases in which these agents are given separately. Occasionally, heroic measures such as the use of adrenal corticosteroids or corticotrophic hormones are necessary, but these medications should not be continued for long-term therapy and always should be employed with consider-

able caution, especially when certain contraindications such as the possibility of a peptic ulcer are suspected.

In selected cases in which a psychogenic overlay contributes to or aggravates the gastrointestinal symptoms, some therapy is necessary along these lines. It may consist of nothing more than reassurance and giving the patient some insight into the problem. When indicated, there should be no hesitancy in seeking the help of a qualified psychiatrist.

Finally, the treatment of gastrointestinal allergy may be enhanced by specific hyposensitization of coexisting allergic disorders. This does not indicate the use of foods in an allergy extract because desensitization to foods by injection is worthless. Reduction of the allergic threshold by counteracting any associated allergies will indirectly help alleviate the gastrointestinal symptoms, especially if the digestive tract is one of the shock organs.

Summary

Gastrointestinal allergy is more common than realized and often is overlooked or misjudged. Awareness of its existence is necessary for proper diagnosis and treatment. Foods are the most common cause of gastrointestinal allergy although other causes may be important. Elimination of the specific offenders, especially food substances, usually results in prompt relief of symptoms and amelioration of the disease.

References

1. Andresen, A. F. R.: Gastrointestinal Manifestations of Food Allergy, M. J. & Rec. 122:271, 1925.
2. Fries, J. H.: Gastrointestinal Manifestations of Allergy, New York State J. Med. 56:3026, 1956.
3. Horesh, A. J.: Gastrointestinal Allergy in Older Children. The Allergic Child. New York, Hoeber Medical Division, 1963.
4. Lee, J. L. & Squier, T. L.: Provocative Diets in Recognition of Food Allergy, J. A. M. A. 142:318, 1950.
5. Pounders, C. M.: Gastrointestinal Allergy in Infancy. The Allergic Child. New York Hoeber Medical Division, 1963.
6. Rinkel, H. J.: Food Allergy: Function and Clinical Application of the Rotary Diversified Diet, J. Pediat. 32:266, 1948.
7. Rowe, A. H.: Food Allergy, Philadelphia, Lea & Febiger, 1931.
8. Vaughn, N. T. & Black, J. H.: Practice of Allergy, St. Louis, C. V. Mosby Co., 1954.

A Body Blow

There is a cloud on the horizon, no bigger than the shadow of a revenuer's hand, which portends great hardship for the scientific publications of the country. The Internal Revenue Service, beguiled by arguments of unfairness to business publications, is considering taxing the advertising revenues of all publications. Heretofore the publications of nonprofit organizations have been exempt. It is to be hoped that the IRS will make haste slowly and give weighty consideration to the service function performed by scientific publications as the voice of the nation's scientific societies.

In the case of the journals that serve the medical profession, taxation of this sort would be disastrous. At a time when costs of paper, printing, and distribution are at an all-time high, advertising revenue is of increasing importance. The dissemination of scientific information is a necessity for medical progress; its publication is a requirement for storage; its retrieval is essential for scientific development. These services are dependent on the commerce of advertising for survival.

It is claimed that this source of revenue makes inordinate profit for the nonprofit organizations. The facts will not bear this out. Many of our scientific journals, those most useful to researchers and practitioners alike, do not break even. If the IRS goes ahead with this needless phlebotomy, many worth-while journals will die, and many worth-while scientific observations and experiments will lie hidden.

Medical journals are a prime means of postgraduate education—starve them and you starve professional competence—nourish them and you prosper the health of the people. We trust the IRS will not burn down the house to get roast pork.—New York Journal of Medicine.

Food Allergy: A Brief Report*

Frederick A. Stenbuck, M. D.

THE commoner effects of food allergy are well known: hives, eczema, asthma and gastrointestinal symptoms. Not so widely recognized are the effects of food allergy on other systems of the body. It is important to be aware of these possibilities when faced by patients with bizarre symptoms not explainable by usual means. Every allergist has his own file of such cases. A few examples will help to bring to your attention the wide variety of responses that can occur.

Case 1.—M. M. was a boy approximately 10 years of age at the time the following was observed: The father was a severely pollen-sensitive patient under treatment. One day he stated that his son suffered from repeated nosebleed. This occurred spontaneously and without trauma. The father suggested the possibility of allergy to food. No skin tests were made but a food diary showed that on each occasion of nosebleed the boy previously had eaten chocolate. Withdrawal of chocolate from the diet was followed by cessation of the nosebleed episodes. Subsequently on several trials reintroduction of chocolate into the diet was again followed by nosebleed. In the course of the investigation it was found that a small amount of chocolate, such as that contained in one or two pieces of chocolate coated candy, did not produce nosebleed but that a larger amount did.

A Notorious Offender

Chocolate is notorious as a sensitizer of the skin and lungs. It should be suspected as an allergen, not only in children who consume so much of it, but in adults as well. An unusual effect of sensitivity to chocolate is shown in Case 2.

Case 2.—L. Y., an adult male, was referred by a cardiologist with the suggestion that his many attacks of paroxysmal tachycardia might be due to sensitivity to food. A thorough history failed to point the finger of suspicion at any particular food. In this instance intracutaneous food tests were done. The only significant reaction to tests for the foods eaten by this patient was that to chocolate. Attention was then focused on this food and further history elicited the fact that the patient in the course of his employment as manager of the local Woolworth store was in the habit, as he put it, of "nipping a piece of chocolate" several times a day when he passed by the candy counter. Abstention from chocolate brought about cessation of the attacks of tachycardia. This was not done without several relapses, as the patient was distinctly dubious about the relationship and at intervals of a few weeks would take chocolate again with subsequent attacks of tachycardia. After several such incidents he was convinced of the cause of the tachycardia and stopped eating chocolate for more than a year, with no recurrence. He then thought that he might have lost his sensitivity to chocolate and one day ate about a quarter pound of it. Tachycardia began about an hour and a half later. Completely convinced after this incident, this patient avoided chocolate, with one exception which is worth recording. Not having been seen for several years he came in about a year after the end of the last World War and gave the following interesting history:

At the time when the armed forces draft was scraping the bottom of the barrel for manpower he was called for physical examination, although at that time he was married, 35 years old, and had three children. Before reporting to the examining center he began to eat chocolate. By the time he was examined his heart rate was approximately 140 per minute. The examining physicians could find no organic cause for this and apparently suspected that he might have taken some medication to cause it. He was kept at the examining center for three days. His clothing was taken from him and he was given army clothing. He was put under strict observation and even accompanied to the toilet by a guard to make sure that he did not take any medication surreptitiously. But there were slot machines in the center containing chocolate bars and the patient made frequent visits to them. In addi-

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*Presented before the Seventh Annual Meeting of the West Virginia State Society of Allergy, held during the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, 1964.

tion, he drank cocoa at meals and when desserts with chocolate in them were served he asked for seconds. For three days his heart rate remained high and he finally was rated 4F and sent home, washed out and weak, but triumphant. After about eighteen hours without chocolate his heart rate returned to normal.

In his recent book, "Vascular Allergy and Its Systemic Manifestations," Dr. J. Harkavy of New York describes two cases of his own of paroxysmal tachycardia due to food sensitivity and cites the literature describing many other such cases. He also describes a case of angina pectoris due to sensitivity to shellfish, and lists the literature describing angina following the ingestion of beef, strawberries, carrots, tomatoes, milk, cheese, eggs and tea. In all these cases permanent relief was obtained by avoidance of the offending food.

The amount of allergen necessary to cause symptoms may be infinitesimally small in the patient who is exquisitely sensitive. A few examples will be given:

Case 3.—B. S., an adult female, had been known for years to suffer severe migraine headaches after ingestion of certain foods, one of them being corn. About 1935 she was taking powdered dried brewers' yeast for "that run-down feeling," it being the fashionable treatment for that ailment at the time. She complained bitterly about the taste of the yeast and asked if it could be had in some other form. Yeast tablets were obtained, the dose being 8 or 10 tablets a day. Shortly after she started to use the tablets she began to complain of one of the prodromal symptoms of a migraine attack: a sense of band-like constriction around the head. This continued for about two weeks but the full migraine attack did not occur.

The only change in eating habits had been the change from brewers' yeast powder to tablets. Inquiry at the plant where the tablets were made revealed that although corn starch was not used as a binder in the tablets, it was used as a dusting powder on the molds in which the tablets were pressed, to keep the tablets from sticking to the molds. When the patient stopped taking the yeast tablets the sense of constriction about the head soon disappeared. The commercial corn starch used in this process contains about 1 per cent corn protein. The tiny amount sticking to the tablets was sufficient to bring on the prodromal symptoms but not the full blown migraine.

The same patient is also extremely sensitive to fish (but not to shell-fish). On one occasion a severe migraine headache with nausea, projectile vomiting and severe diarrhea was brought about by ingestion of a tiny sliver of anchovy concealed in a pitted olive and chewed and swallowed before she became suspicious of the taste. This happened after the patient had successfully avoided fish for many years.

In 1957, Dr. Theron Randolph, of Chicago, at the annual meeting of the American Academy of Allergy reported a case of sensitivity to corn starch used as a sizing in paper boats used to contain foods such as pickles and potato salad. The presence of the starch in the paper boats was easily demonstrated by the ordinary iodine test.

Case 4.—D. W., at the time of this incident, was 14 years old. He was under treatment for asthma due to sensitivity to pollens, fungi and house dust. One day while visiting his uncle (also an asthmatic), he began to have asthma. He asked his uncle if there was some Tedral in the house and was told that there was some in the bathroom medicine chest. He took a tablet without reading the label and in a few minutes was markedly worse instead of better. When he went back to get another tablet he saw that he had picked up by mistake a sample package of ascorbic acid tablets. The ascorbic acid itself was not under suspicion but the excipients listed on the label included lactose, corn starch, talc, acacia and mineral oil. The patient was known to be not sensitive to any of them except acacia and his sensitivity to acacia had not been known up to that time. Subsequent to the incident, an intracutaneous test with acacia resulted in a large wheal with pseudopods and a large erythematous flare.

Case 5.—A. M., when first seen, was a 59-year-old housewife. The history obtained at her first visit was itching and swelling of the mouth and face after drinking fermented drinks such as beer, homemade root beer and wine. She also had swelling of the hands and arms after kneading yeast dough. Yeast was therefore suspected as the cause of the marked swelling of the face which was seen when she first presented herself.

She was told to stop using anything that had yeast in it. Bread was specifically forbidden and she was advised to use Rye Crisp instead. About a week later she returned, still with some swelling of the soft tissues about the eyes, somewhat less marked than at the first visit. Close questioning brought out the fact that she had obeyed all instructions, but having been born in Sweden she had used Swedish "rye crisp" instead of the American variety. Examination of the label on the Swedish "rye crisp" package showed that it was made with rye, salt, water and yeast.

The American variety contains only rye, salt and water. When the patient changed to the domestic Rye Crisp the swelling disappeared. She complained that it did not taste as good, however, as the Swedish variety.

Additives Too

Besides adverse reaction to foods we must keep in mind the possibility of reaction to food additives. Thirty or forty years ago the only commonly used food additives other than colorings were benzoate of soda and sulfur dioxide. These were used to help preserve foods. Today a much wider range of chemicals has been added to the list, e. g., to color our food, to improve its keeping qualities, to help emulsify or to improve its texture.

Systemic Vulnerability

In addition to the cases here described a review of the literature shows a long list of conditions which have been definitely proven to be due to food allergy. In the eye, catarrhal conjunctivitis, phlyctenular conjunctivitis, episcleritis, iritis, ciliary spasm (from eating wheat), retinitis and retinal detachment, and diplopia have been reported. Involvement of cranial nerves as an expression of allergic reaction has been reported many times. And so one can go through the various systems — cardiovascular, blood-forming, joints and muscles, genito-urinary, respiratory, and find documented cases in which allergy to food has been the causative agent.

The Traditional 'Fine Print'

It has been shown that minute quantities of food or additives can produce symptoms in the sensitive individual. Where do these patients encounter them? With the tremendous increase in consumption of canned, packaged and frozen foods, especially since the last war, has come a great number of "booby traps" for the unknowing and unobservant food-sensitive consumer. To most people a can of soup is just a can of soup; perhaps a large percentage of consumers are aware that a can of tomato soup contains tomatoes and that a can of cream of asparagus soup contains both cream and asparagus. But unless the consumer reads the fine print on the label he will not be aware of the many other ingredients present in the contents of the can. And very few persons read the fine print. One of the commonest causes of food sensitivity is wheat. A good example of the unsuspected presence of this allergen is canned soup. Examination of the labels of five varieties of a well known brand of canned soup shows (in small print) the presence of wheat in four. Unfortunately, in the case of many foods, the manufacturer is not required to state the ingredients on the label. Ice cream is one case in point. Since vegetable gums may be used in ice cream (to make it smoother) without stating the gum's presence on the label, the patient just described, who is sensitive to acacia, dare not eat ice cream unless it is homemade. The commercial variety might or might not contain acacia.

Thus, whether or not you specialize in allergy, take the time to go shopping at the supermarket with your wife. Trail along behind her and pick up bottles, boxes and cans. Read the fine print that lists the ingredients. If you have never done this, your medical education is not complete. And do not be surprised if sometime, somewhere, somehow, the memory of what you have read on one of those labels helps you to solve a puzzling case.

Break Them Up

Last year an estimated 125 million disposable medical products were used. A considerable portion of these were disposable hypodermic syringes. Many of these syringes become available in an undamaged condition to young treasure hunters on their way to school. Searching trash barrels can be rewarding to young scavengers. Playing doctor may be more fun than football, particularly if the student has a nice honest-to-goodness hypodermic syringe to stick into a schoolmate. More and more occurrences of this nature are being reported.

Unsterile hypos conveying remains of potentially dangerous material should never be made available. Infectious hepatitis, allergic reactions, tetanus and foreign bodies may be the byproducts. It is so simple to render both needle and syringe unusable. Destroying their usefulness protects both children and addicts. This is the MD's duty. Break them up as you throw them away.—Massachusetts Physician.

The Readership Survey

THE questionnaire enclosed in the January issue of *The Journal* has been completed and returned by approximately 25 per cent of our membership. This is a highly satisfactory return. The questionnaires have been forwarded to the State Medical Journal Advertising Bureau and in due time an analysis will be made and the report will be published in *The Journal.*

Superficial study of the sampling is most interesting to the Publication Committee. Various appraisals of *The Journal* indicate it "is not worth publishing" and "it is the best State Medical Journal in the country." In most categories or specialties the most read feature is the "News Section." There is a demand for more news of county and state activities, so let us have more reports of county activities, sectional meetings and just plain news, personal or collective.

The Publication Committee is particularly beholden to the urologists and ophthalmologists who found the editorials the best part of *The Journal.*

The Journal rated second or third in order of preferential reading. It was often preceded in preference by the *JAMA* or a specialty journal. Many physicians preferred the advertising "throw aways" to any association journal and quite a number of physicians listed their six preferences in this class.

It was grievous to learn that many doctors disliked the amount or type of our advertising. The Publication Committee and our Managing Editor constantly strive for more advertising so *The Journal* may contribute to the financial upkeep and thereby slow down the trend to ever increasing dues.

The least interesting parts of the magazine vary with personality and specialty. Every section from articles to obituaries received some dishonorable mention including the affairs of the Auxiliary. There were many items that members wished included in *The Journal* such as better listing of local and national meetings. A question-and-answer column was one of the most desired features. Competent "CPC'S" were wanted by all specialties.

A feature devoted to new drugs was requested by several members. It is hoped this item will be added in the near future. Finally, many physicians asked for an active "Letter to the Editor" section. With this request the Publication Committee is in thorough accord. Anything concerning medicine and fit to print will be published.

The Committee wishes to thank all the members who gave their personal opinions to the questionnaire.

The President's Page

Guest Author, Mrs. George A. Curry, Morgantown, President
Woman's Auxiliary to the West Virginia
State Medical Association

Medical Ethics and the Doctor's Wife

THAT a thing is new does not of course commend; that it is old does not discredit. The test question is, "It is true or Good?"—Tryon Edwards.

When we apply this test question to the Hippocratic Oath, there is only one answer—"It is good." Medicine's pattern of morality has changed little since the time of Hippocrates. In the well-known oath which he administered to his disciples, he set forth an ideal of professional medical conduct that has remained as a standard down to the present. It is gratifying to note when moral decay is evident all around us, and when some intellectuals or pseudo-intellectuals either politically inspired or falsely inspired by alien philosophies are seeking to becloud our thinking and to further relax our morals, that the medical profession is stressing even greater medical discipline and greater responsibility to the public and to the patient. Just recently, the AMA House of Delegates approved a new expanded program of medical ethics.

How does all this relate to the doctor's wife? When she marries a physician she marries a profession as well, and is subject to its same controls and standards. Medicine becomes her world. She must ever strive to enhance the image of the profession, for as she is judged, so is the profession. Her role on the community stage must be well played. There are many problems in the medical area that need the combined efforts of the doctor and his wife. By working with him she automatically doubles the influence of the medical profession. In her daily contacts, whether it be with the milkman, the TV repairman or her husband's patients, the same high principles of conduct which govern the medical profession must govern her.

A doctor's value is dependent, as is that of the whole medical profession, upon his professional standing and reputation. The doctor's helpmate nowadays has a real fight on her hands to help keep a true picture before the public. She must combat criticism of the medical profession, and must constantly remind her friends and neighbors that the United States has the highest type medical care of any place in the world, and of any period in history, and that this was brought about through the efforts of individual members of the profession. She must never relax in her efforts to fight apathy and complacency, or to stress the importance of individual freedom, especially as it relates to our nation's health.

The thirtieth of March is Doctors' Day. On this day let us recognize and pay tribute to those dedicated individuals whose sacrifice and unselfish service made possible for many of us—Another Tomorrow.

Lizzie Curry

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

SINGLE UNIT TRANSFUSION OF WHOLE BLOOD

This subject has been covered in numerous articles and generally it is the consensus that the use of a single pint of blood in an adult patient is a matter of trying to do too much with too little. If a patient can be treated adequately with a single unit transfusion, then it is doubtful if a transfusion is needed in the therapeutic management of the case. Without a doubt, in the past, the use of single unit transfusion is certainly the greatest abuse of blood transfusion therapy.

In order to justify the transfusion of a single unit of blood, the physician must weigh the indications for transfusion against the hazards and expected results. Roughly speaking, a normal adult might be expected to show a rise of 1.5 grams per cent hemoglobin following a single (500 m.) unit transfusion of blood. Because of the hazards which are attendant to every transfusion, physicians have long recognized that the dispensing of blood and the dispensing of aspirin are entirely different matters. Infections, such as brucellosis, syphilis, malaria and hepatitis, may be transmitted through transfusion. Of these, hepatitis is by far the commonest. According to the American Association of Blood Banks, one out of every two hundred transfusions results in infectious hepatitis. Bacteriologic contaminations while bleeding donors is a rare complication of transfusion. Despite the best precautions of the best run blood bank, we can not prevent the 1 to 2 per cent incidents of allergic and febrile reactions. Fortunately, the transfusion of incompatible blood is a very rare complication. This remarkable decrease in incidence is a reflection of our very real advances in methodology. Despite our best precautions, however, the possibility of incompatible transfusion always presents a nagging possibility. Some other possible transfusion reactions are citrate toxicity, thromboplebitis, air embolism, hemosiderosis and congestive failure due to overload.

The indications for multiple transfusion are well known, but bear repetition. There are five indications for multiple transfusion and these are: to maintain blood volume and manage hypovolemic shock; to maintain oxygen carrying capacity to other blood; to promote and maintain coagulation, as replacement for such diseases as erythroblastosis and certain poisons; and, finally, for use in extra corporal circulation. In multiple transfusion, physicians are aware of the hazards but are also aware of the fact that the rewards of multiple transfusion far outweigh the hazards of giving the transfusion.

When one compares the hazards of transfusion against the expected results of a single unit transfusion, we are hard put to find sufficient indica-

tion for this type of blood usage. So many times in the past, a single unit transfusion has been given as a sort of "pepper upper" and so many times in the past the physician has stated to the patient, "Your blood is a little low and a small transfusion will make you feel so much better." Today, with the knowledge of the dangers that exist in every transfusion, physicians are not as anxious to transfuse as they once were. When should a physician employ a single unit transfusion? In a recent meeting of the American Medical Association's Conference on Blood and Blood Banking in December, 1964, four possible indications for single unit transfusion were given. These are as follows: A patient in shock who responds adequately to a single transfusion, an older anemic patient with angina pectoris whose pain will be relieved by single transfusion, a recoverable anemic in congestive failure who will be helped by transfusion before a specific therapy becomes effective, and treatment of patients with chronic refractory anemia, such as aplastic anemia and hemolytic states.

In summary, therefore, the indications for single unit transfusion of blood are quite limited, and the physician must weigh the hazards of giving the transfusion against the expected results. He must recognize that any transfusion is a potentially dangerous procedure, and should be given only after careful consideration and study of the indications.—*Guest Editorial by Herman Fischer, M. D.*

WHAT ABOUT OUR 'IMAGE'?

Late in September, we were watching the "Ed" Sullivan show on T.V. Very proudly, and with a great puff by "Ed", a comedian by the name of Alan King took off on the "doctors." To me, what he said, by and large, was not funny—and sometimes hurt. Why? Well he hit the spots in the patient's view where unthinking and insensitive doctors often cause such discomfort by their actions and upset the patient.

He went after the apparent sacredness of the golfing Wednesdays and Sundays—stating that if you wanted to find a doctor on those days, look in the sand-trap. He hit cold examining rooms, uncomfortable furniture, old, worn out magazines, and other current complaints about doctors and their offices, and really painted a pretty bad picture of our profession, by giving the overall impression that we were a callous group of individuals. What was the audience reaction to all of this? Why they loved it, because in their minds King was giving them an image of their doctor.

In this issue of *Medical Times* two papers, "*A Moral Concept of the Practice of Medicine*" and "*Doctor, It Hurts*" discuss our diminishing reputation as a profession and why this is happening, because of the fundamental changes in the philosophy of many practitioners of the *Art* relative to the practice of medicine.

In the first paper it is pointed out that we exist only because people need us. People are not perfect, but we must treat them irrespective of the trouble they may cause us because they are sick (or not sick). We must do this with thought in mind that we will treat them in the way we would like to be treated or have our family treated. We must be honest in all our dealings and be strong enough to always have the patient's best interests in mind. We must strike down the idea of "You scratch my back, and I will scratch yours." We must not be dishonest to ourselves.

Furthermore, we must not disparage our colleagues. Otherwise we become malicious gossips who degrade our profession. You may not honor, and may not like a colleague, but keep your mouth shut about it in the presence of patients. Do your talking, if talk you must, before the disciplinary committee of your local society.

We must give service over and beyond what tradesmen give. The other day we heard a very intelligent woman say: "A year ago when a pipe froze and broke and water was all over the garage, I called the plumber and even though it was Sunday he was there in ten minutes, but two weeks later when my husband broke his leg falling off a ladder, I couldn't find our family doctor and the only advice I could get was to take him to the emergency room of our local hospital." An epsiode like this doesn't help your image or my image, doctor! When we don't carry out our traditional function of responding to the suffering of man, our profession goes downhill.

It must be remembered that one of our most treasured (and widely talked about) privileges in our profession is the physician-patient relationship. Anything we do to degrade it brings about a growing dissatisfaction with our profession. We must not say one thing and do another. Even with the quantity of patients which we have to serve, we must do our level best to protect and foster the physician-patient relationship. If we maintain it at a high level, we will never have to worry about a system of medicine so ineptly called "Socialized Medicine." Our patients will see that we are not saddled with it.

We must remember that what patients want, as is pointed out in the second paper "is good

medical care when and where it is needed." If they get that, our image will never be endangered. But in our odd and unthinking ways we often do things which the patients feel decrease the value of our care in their eyes. We don't make house calls, we don't go out easily after hours, we make patients wait, we tend to be patronizing to patients, and we do many other things which bias patients against us.

While there is little questioning the fact that we take far better care of our patients than did physicians fifty years ago, we seem to have lost our reputation for humanitarianism. We must be prepared, as Jenkin Lloyd Jones said sometime ago at a Public Relations Institute sponsored by the AMA, "like the fire department, to answer all alarms."—*Perrin H. Long, M. D., in "Medical Times."*

MIGRAINE HEADACHES

There are many people who suffer from chronic headaches; indeed, headaches, as many physicians will testify, are one of the most common complaints of mankind. In a paper given before the American Medical Association in San Francisco last June Dr. Arnold L. Friedman[1] called attention to recent advances that have developed through researches on chronic headache and its causes. He discussed several types of chronic headache, but in this editorial we will limit our discussion to migraine headaches.

There is a school of thought which holds that there is such an entity as a migraine personality. Friedman denies this, although he describes in some detail the type of person who often suffers from migraine. He emphasizes that in general such people are intelligent, sensitive, methodical, and perfectionistic in manner, who in dealing with stressful situations use intellectual techniques. He believes further that the migraine patient has pushed beyond his capacity to produce which increases his feeling of inadequacy and frustration, and causes him to react with anxiety. In this connection, however, it is probably difficult to distinguish between cause and effect.

Friedman believes that the pain of migraine headache is probably caused by the concurrent dilatation of a single extracranial artery and a periarterial tissue reaction. Some evidence has been obtained indicating a neurogenic cause for the dilatation. It is believed that the periarterial tissue reaction is induced by the accumulation of a substance or substances which can induce dilatation of small vessels, edema and tenderness of the tissues. Just what the nature of these substances are remains unknown. Friedman and his co-workers have investigated a number of them; they have injected serotonin, acetylcholine, adenosine triphosphate, and still others. None of these induced an attack of migraine. Furthermore, no elevation of serotonin content of venous and arterial blood during attacks of migraine was found, nor was the urinary 5-hydroxyindole acetic acid increased.

Since in the preheadache phase, visual, sensory and psychic disturbances are common it is thought that the central nervous system is the site of origin. Further proof of this is that abnormal electroencephalograms may be found in 25 to 40 per cent in migraine patients.

Certain other physiologic changes may occur in the body, such as cyclic changes in fluid balance manifested by local and general edema and electrolyte retention. It is well known that diuresis often occurs as the headache begins to subside. Friedman reports, however, that overhydration and the use of antidiuretics did not provoke attacks of migraine.

Since the exact site of the origin of migraine headache still remains unknown, it is obvious that a great deal more of painstaking research is needed. Indeed, Friedman emphasizes that more rigidly controlled studies and more sophisticated biochemical techniques are needed in studying the cause of migraine.

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1. Friedman, A. P.: Reflection on the Problem of Headache. JAMA, 190:445, (Aug.) 1964.

Death by Default

The public must be protected of course, but isn't there such a thing as over-protection? Certainly it is no problem to prevent the introduction of any drugs with potentially harmful or mildly harmful side-effects. It's simple—just don't develop any new drugs, or at least make it very difficult for a new drug to be tested and/or marketed. The only difficulty here is that many lives and the improved health of many others would be lost by default, that is, drugs that could be of benefit would never be developed. This is just as wrong as allowing anything and everything to be pushed onto the drug market.

For the non-medically orientated it is quite easy to understand the sad results of a thalidomide deformed baby but far less easy for many to comprehend the equally sad results of those lives that can be lost by default.—Joseph P. Schaefer, M. D., in *New Physician.*

Cancer survival rates have improved from 1937's rate of one in seven to today's one in three. Early diagnosis, better surgical and radiological techniques and more than a dozen new therapeutic agents are responsible.

GENERAL NEWS

Dr. Walter H. Judd Honor Guest At 98th Annual Meeting

Dr. Walter H. Judd, former medical missionary and congressman from Minnesota, will be among the honor guests at the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Walter H. Judd, M. D.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, announced that Doctor Judd had accepted an invitation to appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 26.

Doctor Judd, who is a native of Rising City, Nebraska, received his M. D. degree in 1923 from the University of Nebraska School of Medicine. He had postgraduate training at The Mayo Foundation of the University of Minnesota and then served in China as a medical missionary.

Doctor Judd returned from China in 1938 and spent the next two years speaking throughout the United States in an attempt to arouse Americans to the menace of Japanese military expansion and the threat to world peace of communist subversion in China.

Following two years of private practice in Minneapolis, he was a successful candidate for Congress from Minnesota's Fifth Congressional District. He served ten terms in the House of Representatives and is a nationally recognized authority on U. S. foreign policy. As a member of the Committee on Foreign Affairs for 16 years, he played an important role in establishing our relief, re-armament and economic developments abroad. He was defeated in a bid for reelection to Congress in 1962.

More than 20 universities have conferred on Doctor Judd honorary doctorate degrees. In a Congressional poll in 1962, he was voted by his colleagues in the House as one of its five most influential members, the only one so named from the minority party. Doctor Judd has been active for many years in organized medicine and is currently serving as a member of the Judicial Council of the American Medical Association. He was the recipient of the AMA Distinguished Service Award in 1961.

Doctor Judd is a contributing editor to *Reader's Digest* and his most recent article, "Medicare — Or Medical Care?", appeared in the February 1965 issue.

Program Committee Busy

Plans for the 1965 annual meeting are nearing completion. The Program Committee has been busy since the final day of the 1964 meeting and the names of the prominent physicians and surgeons who have accepted invitations to appear as guest speakers will be announced in *The Journal* during the coming months.

Three general scientific sessions will be held on Thursday, Friday and Saturday mornings, August 26-28. As usual, meetings of the Association's sections and affiliated societies will be held during the afternoon hours.

In addition to Doctor Stevens, the other members of the Committee are Drs. Richard W. Corbitt of Parkersburg, Jack Leckie of Huntington, Kenneth G. MacDonald of Charleston, and Maynard P. Pride and Clark K. Sleeth of Morgantown.

Two Sessions of the House of Delegates

The House of Delegates will meet twice during the meeting. The first session will be held on Wednesday afternoon, August 25, and the second session on Saturday afternoon, August 28.

The Pre-Convention Meeting of the Council will be held on Wednesday morning, August 25. This will mark the first time in many years that the meeting of the Council will be held during the morning hours of the day preceding the formal opening of the Conven-

tion. Also, the first session of the House of Delegates has been moved from Wednesday evening to the afternoon hour.

Auxiliary Entertainment Program

As usual, the entertainment program will be under the direction of the Woman's Auxiliary. The Program Committee has set aside Friday evening for the main entertainment feature for physicians, their wives and guests.

Dr. C. A. Hoffman Named to Board Of Blue Shield Plans

Dr. C. A. Hoffman of Huntington, a past president of the West Virginia State Medical Association, was recently elected to membership on the Board of Directors of the National Association of Blue Shield Plans.

He will serve on the Board as physician representative for Blue Shield Plans in West Virginia, Kentucky, Maryland, Virginia, North Carolina, South Carolina and the District of Columbia.

Doctor Hoffman is currently a member of the House of Delegates of the American Medical Association and has served since 1962 as a member of the AMA Committee on Insurance and Pre-Payment Plans. He is a past president of the Mid-Atlantic Section of the American Urological Association and is now serving as treasurer of the national organization.

Pediatric Meeting in Miami Beach

The annual spring session of the American Academy of Pediatrics will be held at the Americana Hotel in Miami Beach, Florida, April 26-29.

All pediatricians and other physicians interested in the treatment of children's diseases are invited to attend the meeting. The scientific program will include closed circuit television and panel discussions as well as scientific and industrial exhibits.

Further information may be obtained by writing the American Academy of Pediatrics, 1801 Hinman Avenue, Evanston, Illinois 60204.

Medical Meetings, 1965

The following is a partial list of national, state and district medical meetings scheduled for 1965:

March 26-27—National Rural Health Conference, Miami Beach.
Apr. 18-21—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
April 30-May 2—W. Va. Chapter, AAGP, Wheeling.
May 9-14—Ohio State Medical Assn., Columbus.
May 15-16—W. Va. Radiological Society, Beckley.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia

W. Va. Acad. Oph. and Otol. To Meet At The Greenbrier, April 18-21

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 18th annual meeting at The Greenbrier in White Sulphur Springs, April 18-21. Dr. R. Alan Fawcett of Wheeling, the president, will preside during the four-day meeting.

Doctor Fawcett announced that six out-of-state physicians have accepted invitations to present papers at the general scientific sessions.

The speakers on ophthalmology and their subjects are as follows:

"Complications of Cataract Surgery," (Two Lectures).—Philip M. Lewis, M. D., Memphis Tennessee.

"Complications of Corneal Surgery," and "Complications of Cataract Surgery."—Arthur G. DeVoe, M. D., New York City.

"Neuro-Ophthalmological Aspects of Myasthenia Gravis," and "Clinical Significance of Isolated Oculomotor of Abducena Paralysis."—Nathan S. Schlezinger, M. D., Philadelphia.

Speakers on otolaryngology and their subjects are as follows:

"Ossicular Substitutes and Repair," and "Treatment of Meneire's Disease."—David Austin, M. D. Chicago.

"The Evaluation and Treatment of a Lump in the Neck," and "The Management of Parotid Gland Tumors."—Edwin W. Cocke, M. D., Memphis.

"Vertiginous Patient," and "Control of Allergy with Heparin."—David A. Dolowitz, M. D., Salt Lake City, Utah.

Physicians throughout the State have been invited to attend the four-day meeting. A registration fee of $35 will cover all scientific sessions and social functions.

In addition to Doctor Fawcett, the other officers of the Academy are as follows: Dr. Ralph W. Ryan of Morgantown, president elect; Dr. Worthy W. McKinney of Beckley, secretary-treasurer; and Dr. J. E. Blaydes, Jr., of Bluefield, assistant secretary-treasurer. The directors are Drs. William C. Morgan, Jr., and Alfred J. Magee of Charleston, and Edward Shupala of Parkersburg.

Additional information may be obtained by writing the Secretary, Dr. Worthy W. McKinney, Professional Park, Beckley.

Seminar on Premature Care

The third Annual Seminar on Premature Care, sponsored by the Good Samaritan Hospital, will be held in Cincinnati on April 15. The one-day session will begin at 1:00 P. M.

The guest speakers will be Drs. Gerard B. Odell of Baltimore, Virginia Apgar of New York City, and Henry C. Cramblett of Columbus.

There is no registration fee but physicians planning to attend are requested to contact Dr. James J. Englert, Good Samaritan Hospital, Cincinnati, Ohio.

AMA House of Delegates Endorses Eldercare Program (H.R. 3727)

The House of Delegates of the American Medical Association met in special session in Chicago, February 6-7, and gave unanimous approval and support to the AMA Eldercare Program and to the Herlong-Curtis Eldercare bill (HR 3727), which embodies the basic principles of the AMA Program.

Drs. C. A. Hoffman of Huntington and Frank J. Holroyd of Princeton, AMA Delegates from West Virginia, were in attendance at all sessions of the House during the two-day meeting. Doctor Hoffman served as Chairman of the Reference Committee on Credentials.

Also attending the meeting in Chicago was Dr. Albert C. Esposito of Huntington, President of the State Medical Association.

Summary of Chicago Meeting

The following summary of the Chicago meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

In acting upon six resolutions and reports from the AMA Board of Trustees, Council on Legislative Activities and Council on Medical Service, the House of Delegates:

(1) Reaffirmed its opposition to the King-Anderson bill (H.R. 1 and S. 1) and all similar measures;

(2) Commended the Board of Trustees and its Task Force for implementing and funding a program of public education on the AMA Eldercare Program and gave them a standing vote of confidence;

(3) Called for study of the "desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need help;"

(4) Adopted a statement on Standards for Health Care Programs, and

(5) Urged that the professional services of pathologists, radiologists, physiatrists and anesthesiologists should be excluded from the provisions of any bill which excludes other physicians' services.

AMA Eldercare Program

First announced on January 9 by AMA President Donovan F. Ward, at the Association's Kerr-Mills Conference in Chicago, the AMA Eldercare Program would encourage the use of voluntary health insurance or prepayment plans in the implementation of Kerr-Mills programs, permit the state to have a health-oriented agency supervise or administer the program, provide for use of an income information statement as the sole eligibility test of need, and provide for a wide spectrum of medical, surgical and hospital benefits with sliding-scale eligibility so that a citizen 65 and over would pay all, part or none of the cost of the insurance or prepayment policy, depending on his income.

The Eldercare Bill

These principles are incorporated in the Eldercare Act of 1965, introduced on January 27 by Representatives A. Sydney Herlong, Jr., (D., Fla.) and Thomas B. Curtis (R., Mo.), amending the Kerr-Mills law to authorize broad health insurance coverage for elderly persons.

The Herlong-Curtis bill would authorize federal grants to the states on a matching basis to help persons 65 years of age and older pay the costs of the health insurance or prepayment policy if they could not afford it otherwise. The bill would provide for utilization of Blue Shield and Blue Cross plans and private health insurance companies.

The cost of such coverage would be borne entirely by government for those elderly individuals whose income falls below limits set by each state. For individuals with incomes between the minimum and a maximum, government would pay a part of the cost on a sliding scale according to income. Individuals with income above the maximum would pay the entire cost, but they would have the benefits of an income tax deduction for such payments.

Persons under 65 years of age also would be given an income tax deduction for the amount of premiums paid on health insurance policies for elderly relatives.

Doctor Ward's Address

Condemning the King-Anderson bill and urging support of the Eldercare program, Doctor Ward told the House on the first day of the Special Session:

"Are 200,000 doctors wrong in urging the Congress to give serious consideration to the one measure now before it that offers genuine medical and hospital benefits to the needy aged? This is a bill authored neither by the Republican party nor the Democratic party. It is a bill for bipartisan parentage—the Herlong-Curtis Eldercare bill, numbered H.R. 3727. We urge Congress to compare, and the people to compare, this bill with its genuine benefits and realistic financing—and with its provision allowing for administering a health program through health agencies of the states—to compare it feature-by-feature with Medicare.

"If the drums can be stilled long enough to make this comparison, it will be found that the Herlong-Curtis Eldercare bill can cover not only the cost of hospital care and nursing homes for the aged, but also payment of physicians and surgical and drug costs—which Medicare would not do."

Doctor Ward declared that "it is never too late to pass good legislation and defeat bad legislation. The one thing in this historic decision—the only thing—that may truly come too late, is regret."

Education Program

Dr. Percy E. Hopkins, Chairman of the Board of Trustees, reported to the House that the AMA's current effort to tell its story to the people and to the Congress is being financed through the allocation of a portion of the Association's reserve fund. In response to a number of questions raised during the open discussions, the delegates also were told that the

education program will not require a dues increase or a special assessment. The program will be national in scope—involving magazines, radio and television—but maximum grass roots effort was urged upon the entire AMA membership and the Woman's Auxiliaries.

Health Care Legislation

Declaring that "it is essential that the position of the AMA be made clearly apparent while at the same time remaining responsive and flexible in legislative developments," the House passed a resolution reaffirming earlier positions established on federal medical care programs.

Specifically included was the reaffirmation of the policy established by the House of Delegates at the 1964 Clinical Convention, which urged component associations to stimulate state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care is available.

The House defeated a motion that "a medical and hospital service plan with minimum benefits specified, one and the same across the nation from the point of view of the benefits offered, be prepared to accompany H. R. 3727" (the Herlong-Curtis Eldercare bill).

The House tabled that portion of the Reference Committee on Legislation and Public Relations Report dealing with Resolutions No. 3 and No. 5, both of which called for the AMA to propose legislation which would extend health insurance coverage to all *needy* persons regardless of age.

In considering this proposal, the House adopted Resolution No. 7, introduced by California, one portion of which asked that "the AMA Board of Trustees, the Council on Medical Service and the Council on Legislative Activities (a) study the desirability and feasibility of extending the principle of federal and state aid under the Kerr-Mills principle to persons below the age of 65 who need help and (b) report their recommendations as early as possible to the AMA Board of Trustees and House of Delegates as a basis for formulation of future AMA policy in this regard."

After adopting the California resolution, the House voted not to "lift from the table" the portion of the Reference Committee Report dealing with Resolutions No. 3 (Indiana) and No. 5 (Michigan).

Standards for Health Care Programs

The House adopted the following principles as essential to sound health care programs:

1. No person needing health care shall be denied such care because of inability to pay for it.
2. It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.
3. Every level of government (municipal, county, state and federal) should assume a responsible share in the financing of such programs.
4. The health care provided by such programs should be adequate and should be equal in quality to that available to those who can afford to pay.
5. Maximum use should be made of voluntary prepayment and insurance mechanisms.
6. Administration of such a program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.
7. Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.
8. Any such health care program should provide funds only, and not direct services.
9. Funds for such programs should come from general tax revenues and not from Social Security taxes.

Medical Service Report

In approving the report of the Council on Medical Service, the House adopted the following statement:

"The Council believes it is important for the profession to note that, while suggested mechanisms for providing health care to the needy have changed as the nation's social and economic structure has changed, the basic underlying concepts of the American Medical Association, upon which our policy statements have been made, have not changed."

Physicians and Wives Urged To Write Congressmen

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, recently addressed the following letter to the president of each county medical society and Woman's Auxiliary:

"At no time in the history of medicine has the need for the cooperation of the medical profession and its auxiliary been more acute than at the present time.

"We have just learned that the House Ways and Means Committee will begin hearings on the new version of the King-Anderson Bill this coming Wednesday.

"I write to urge that you, as the leader of our profession in your area, set the wheels in motion to get the avalanche of letters to Washington as noted to you in the urgent message from Dr. Donovan Ward, the President of the American Medical Association.

"I know there are many who are faint of heart at this time, but let me remind you of England's darkest hour and her return to glory only with the aid of all the people of that tiny island. Our need is great, but only by a massive cooperative effect, can we hope to change some of the provisions of the Administration's Health Care Plans for the Elderly.

"Let me again urge you and everyone you know to write to our Senators and Representatives asking them to support the doctors' "Eldercare Program" (HR 3727).

"This may be our last chance to retain the heritage of free medicine, which we hope to pass on to another generation."

(Signed) Albert C. Esposito, M. .D.

Funds Needed for Construction Of New Medical Facilities

At least $258,307,000 is needed for medical facilities construction to meet present needs of West Virginians.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health," discussed the latest revision of the State Plan for Hospital and Medical Facilities Construction, approved by the State Board of Health and the U. S. Public Health Service.

Doctor Dyer pointed out that a total of 11,000 additional hospital beds are needed. The greatest deficiency is in facilities for long-term care where 6,091 beds are required, at an estimated cost of $73,092,000, and in mental hospitals, where 4,370 beds are needed at a cost of $87,400,000.

Also required are 20 rehabilitation centers costing $22,000,000, 91 diagnostic and treatment centers costing $72,800,000 and 13 public health centers costing $1,950,000.

He noted that 95 per cent of the need for general and tuberculosis hospital beds has been met. Requirements of the present plan call for construction to accommodate only 412 general and 51 tuberculosis hospital beds.

Present estimates include costs of construction and equipment based on national averages. "Before we meet our needs," he said, "it is probable that figures will pyramid, reflecting steadily rising costs."

Doctor Dyer noted that during the 17 years of the Hill-Burton program, $37,000,960 in federal matching funds have been allocated to the state. This amount, combined with $57,008,707 in local matching funds, resulted in an investment of $94,009,667 in hospitals and other health facilities during the period.

In another issue of the publication Doctor Dyer discussed a 30-year history of various communicable diseases in the state. He pointed out that from 1929-33, West Virginia recorded 5952 cases of diphtheria; from 1934-38, an additional 4769. In contrast, no cases of diphtheria were recorded in 1961 or 1964 and only 10 cases for the five years from 1959-63.

Between 1934-38 there were 2502 cases of typhoid fever. No cases of this disease were recorded during 1964 and only 53 cases in 1959-63.

Doctor Dyer noted that there were 63 cases of smallpox between 1934-38. Not a single case of smallpox has been confirmed since 1948 in the state.

Polio cases were greatest between 1944-48 with 2205 cases reported in the state. One case of polio was reported in 1964 involving a 3-year-old child who had not been vaccinated.

Doctor Dyer related in another issue of the publication that the average life expectancy for Americans in 1900 was 47.3 years as compared with 70 years in 1962. For men the life expectancy was only 46.3 years in 1900 and for women an additional 24 months, or 48.3 years. In 1962 the life expectancy for men was 66.8 against 73.4 years for women.

He pointed out that during the early months of life, females have a better chance of survival. Diseases of early infancy produced a death rate of 23 per 100,000 for females in the state during 1963 against 36.6 for males. The rate for males is about 53 per cent higher.

Annual Meeting of Maryland Society In Baltimore, April 21-23

Physicians in West Virginia have been extended a cordial invitation to attend the 167th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland which will be held at the Alcazar in Baltimore, April 21-23.

There is no registration fee and study hour credits will be given by the American Academy of General Practice. There also will be scientific and industrial exhibits.

Physicians interested in attending the meeting should contact Dr. Richard T. Shackelford, 1211 Cathedral Street, Baltimore, Maryland.

Refresher Course in Pediatrics In Philadelphia, May 24-28

A refresher course in pediatrics, sponsored by the Children's Hospital of Philadelphia and the Department of Pediatrics at the University of Pennsylvania School of Medicine, will be held in Philadelphia, May 24-28.

The five-day course will consist of lectures and clinics, given by members of the faculty staff, in selected aspects of contemporary pediatrics in which important advances are being made.

Tuition is $150 and further information may be obtained by writing the Post-Graduate Education Committee, Children's Hospital of Philadelphia, 1740 Bainbridge Street, Philadelphia, Pennsylvania.

Heart Association Publication Available to Physicians

A new edition of the Heart Association's catalogue, "Publications and Visual Aids for Physicians," is now available for distribution by physicians to their patients.

In addition to listing the varied materials the Association produces for physician education, the catalogue also itemizes materials for the education of patients.

Copies of the catalogue may be obtained without charge by writing the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia.

PG Course in Urology

A postgraduate course on "Advances in Urology" will be presented at the Cleveland Clinic Educational Foundation in Cleveland, March 17-18.

The two-day course will be presented by staff members of the Cleveland Clinic assisted by several guest speakers. The registration fee for the course is $30 and acceptances will be made in the order of application.

Further information may be obtained by writing Dr. Walter J. Zeiter, The Cleveland Clinic Educational Foundation, 2200 East 93rd Street, Cleveland, Ohio.

Dr. George L. Grubb, third from left, receives a past president's plaque from Dr. Kenneth G. MacDonald, the toastmaster, during the annual dinner-dance of the Kanawha Medical Society which was held at the Charleston Press Club on January 23. Also shown, left to right, are the following past presidents of the Society and an officer of the State Medical Association: Drs. G. G. Irwin; Carl B. Hall; Seigle W. Parks, Vice President of the Association; and T. P. Mantz and Milton J. Lilly, Jr.

Shown in the other photo are the officers for 1965. Left to right, Drs. George L. Grubb, Chairman of the Council; George R. Callender, Jr., Vice President; Edward Jackson, President; and Jerill D. Cavender, Secretary.

Ob.-Gyn. Meeting in San Francisco

The 13th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held at the Civic Auditorium in San Francisco, April 4-8.

More than 2,500 physicians are expected to attend the meeting which will feature discussions of the role of the physician in marriage and family problems, amenorrhea, early fetal loss, cervical cancer, reproductive biology, dysfunctional bleeding, perinatal loss, sociologic and medical aspects of sterilization, toxemia, and bleeding in late pregnancy.

Further information may be obtained by writing the American College of Obstetricians and Gynecologists, 79 West Monroe Street, Chicago Illinois 60603.

Cancer Meeting in Philadelphia

The Annual Scientific Session of the American Cancer Society will be held at the Drake Hotel in Philadelphia on June 16.

The one-day symposium on "Hormones and Chemotherapy for Cancer—A Critical Appraisal" is open to all physicians and students.

Further information may be obtained by writing the American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

New Association Member

Dr. James A. Gardner, Appalachian Regional Hospital, Man (Logan). Doctor Gardner, a native of Philadelphia, received his M. D. degree in 1954 from the University of Glasgow in Scotland. He interned at the Royal Infirmary in Glasgow, 1954-55, and served a residency at Beckley Memorial Hospital, 1959-64. He served as a Captain in the Medical Corps of the United States Air Force, 1957-59, and his specialty is general surgery.

Conference on Pulmonary Diseases In Roanoke, March 7-9

The 13th Tri-State Conference on Pulmonary Diseases will be held at the Hotel Roanoke in Roanoke, March 7-9. The Conference is jointly sponsored by the Thoracic Societies of North Carolina, Virginia and West Virginia.

The first session will be held on Sunday evening, March 7, and the guest speaker will be Dr. Gordon M. Meade of New York City.

The session on Monday morning, March 8, will be devoted to a discussion of hospital admissions at the Medical College of Virginia in Richmond and the West Virginia University Hospital in Morgantown. Doctor Meade will serve as moderator for the morning session.

On Monday afternoon, Dr. William G. Sealy of Durham, North Carolina, will serve as moderator for a discussion of admissions at the Eastern North Carolina Sanatorium.

The session on Tuesday morning, March 9, will be devoted to a discussion of "Diagnostic Problem Cases." Dr. Richard Lester of Richmond will serve as moderator and the other participants will be Drs. George R. Minor of Charlottesville and Edward S. Roy of Richmond.

Physicians from West Virginia who plan to attend the Conference are asked to inform the West Virginia Tuberculosis and Health Association, P. O. Box 341, Charleston, West Virginia. The registration fee is $7 and physicians planning to attend should make their own arrangements directly with the Reservation Manager at the Hotel Roanoke.

The quality control for each batch of one tranquilizer drug requires 38 employees, 14 departments, 114 operations, 134 raw tests and assays, 24 days of work, and 31 different materials before the drug can be put on the market.

Spring Meeting of Radiological Society in Beckley

Dr. Jacob Gershon-Cohen of Philadelphia will be the guest speaker at the spring meeting of the West Virginia Radiological Society which will be held in Beckley, May 15-16.

Doctor Gershon-Cohen, who is Assistant Professor of Radiology at the University of Pennsylvania Graduate School of Medicine, will discuss "Mammography." There also will be a film session and a business meeting.

Physicians planning to attend the meeting should contact Dr. Ilona D. Scott, P. O. Box 24, White Oak, West Virginia.

ACP Course in Atlanta

The American College of Physicians will sponsor a post-graduate course on cardiology in Atlanta, Georgia, March 15-19. The course has been arranged by the Emory University School of Medicine and will be presented at Grady Memorial Hospital.

Doctor J. Willis Hurst, the director, announced that the five-day course will be divided into 10 units of approximately four hours each. The faculty will consist of at least 20 nationally known guest speakers and the registration fee will be $60 for members and $100 for non-members.

Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

'Resident's Day' Program in Detroit

The Seventh Annual "Resident's Day" in Obstetrics and Gynecology will be held at the headquarters of the Wayne County Medical Society in Detroit on March 24. The one-day program will be sponsored by the Wayne State University School of Medicine. There will be no registration fee and physicians in West Virginia have been issued a cordial invitation to attend the meeting.

Further information may be obtained by writing Dr. Charles S. Stevenson, Wayne State University School of Medicine, 1500 Chrysler Expressway, Detroit 7, Michigan.

Symposium on Genito-Urinary Disease

A Symposium on Genito-Urinary Disease will be conducted by the Department of Radiology of the University of Kentucky College of Medicine in Lexington, March 29-April 2.

The program is designed to appeal to physicians and surgeons interested in the genito-urinary system as well as radiologists. There will be 13 guest speakers in addition to members of the faculty of the College of Medicine.

Further information may be obtained by writing Dr. Nicholas J. Pisacano, University of Kentucky College of Medicine, Lexington, Kentucky 40506.

Make Your Reservation Now !

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 98th Annual Meeting at The Greenbrier in White Sulphur Springs, August 26-28, 1965. Application forms for room reservations were enclosed in a bulletin mailed recently to each member. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

Polio Seen Nearing Vanishing Point in the United States

Without the Salk Vaccine which came into use in 1955, and the Sabin Vaccine of 1961, some 35,000 American children and adults might have been stricken by poliomyelitis last year, the Health Insurance Institute said recently.

As it turned out, 1964 marked the lowest point ever in polio incidence in the United States—only 121 reported cases. The year before that, 449 cases. Moreover, there was no seasonal rise or noticeable "outbreak" in 1964. The year before there were eight outbreaks of paralytic polio. And the majority of cases in these outbreaks were among unvaccinated persons.

The Institute, reporting on its analysis of U. S. Public Health Service data, said that this infectious disease which often cripples or kills (8,822 deaths from 1952 through 1961) its victims, may be nearing the vanishing point in this country.

In any case, the success in arresting high polio incidence in the U. S., as well as many other countries, fixes the two vaccines as great victories for medical science ranking alongside the preventive measures used against cholera, smallpox, diphtheria, yellow fever, etc.

The effectiveness of the Salk Vaccine showed up dramatically after 1955, the year it was approved for general use and then given widespread application. Polio incidence dropped from 28,985 in 1955 to nearly half that number the next year—15,140.

By 1960, the year before the Sabin Vaccine came into use, the incidence had dipped to 3,190. In 1961 and 1962, cases numbered 1,312 and 910, respectively.

Cardiac Symposium on March 31

Physicians in West Virginia have been invited to attend a Cardiac Symposium which will be held on March 31 at the Marriott Twin Bridges Motor Motel on the Virginia side of the 14th Street Bridge in Washington, D. C.

The one-day meting will be sponsored jointly by the Washington Heart Association and the Heart Association of Northern Virginia, Inc. Further information concerning the program may be obtained by writing Mrs. Anna C. Van Sickler, 609 North Edgewood Street, Arlington, Virginia 22201.

The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

In Diverticulosis and Diverticulitis...

METAMUCIL® brand of psyllium hydrophilic mucilloid

"**Diverticulosis** ... a low-roughage diet is advisable.... Constipation is avoided, preferably by the daily use of Metamucil.

"**Diverticulitis** Mild, chronic symptoms of diverticulitis, such as diarrhea or flatulence also are treated[1] by low-roughage diet, adequate fluid intake and Metamucil. . . ."

Usual Adult Dosage: One rounded teaspoonful of Metamucil (or one packet of Instant Mix Metamucil) in a glass of cool liquid one to three times daily.

Metamucil is available as Metamucil powder in containers of 4, 8 and 16 ounces and as flavored Instant Mix Metamucil in cartons containing 16 and 30 single-dose packets.

1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

• Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.

PHYSICIANS, nurses and dentists in West Virginia have been invited to attend the First Annual Cancer Teaching Day at the West Virginia University Medical Center on Saturday, April 24, beginning at 9 A. M.

The principal speaker will be Dr. James F. Holland, Director of the Cancer Clinical Research Center at Roswell Park Memorial Institute in Buffalo, New York.

Dr. Alvin L. Watne, Cancer Coordinator at The Medical Center, said the Teaching Day program "will bring out the newest advances in cancer being developed at our Medical Center and elsewhere in the nation."

"This information," he added. "will help physicians to keep abreast of current advances being made in this rapidly progressing field of cancer diagnosis and treatment."

Teaching Day is being sponsored by the Charleston Foundation for Research, West Virginia Division of the American Cancer Society, and the WVU Medical Center.

Doctor Holland will speak Saturday morning on "Leukemia Treatment—A Crucible and Proving Ground."

A native of Morristown, New Jersey, Doctor Holland received his M. D. degree in 1947 from the Columbia University College of Physicians and Surgeons. Following his graduate training, Doctor Holland served in various capacities at Columbia University, Francis Delafield Hospital in New York and the National Cancer Institute.

In 1954, Doctor Holland joined Roswell Park Memorial Institute as associate chief of medicine. Two years later he was named Chief of Medicine A. He has been appointed an associate research professor of medicine at the University of Buffalo, a member of Acute Leukemia Task Force of the National Cancer Institute, and a member of the Chemotherapy Panel of the International Union Against Cancer.

Doctor Holland also is a member of the American Association for Cancer Research, American Association for the Advancement of Science, American Federation of Clinical Research and American Society for Hematology.

Eight members of the School of Medicine faculty also will present papers during the morning session. The speakers and their subjects are as follows:

"Clinical Applications of Lymphangiography in Malignant Diseases."—Drs. Miranda Orteza and D. Franklin Milam.

"West Virginia University Experience in Surgical Treatment of Lung Cancer."—Drs. Richard A. Currie and Thomas J. Tarnay.

"Newer Techniques in the Diagnosis of Brain Tumors."—Dr. Robert G. Nugent.

"Treatment of Recurrent Pelvic Cancer."—Dr. Dean R. Goplerud.

"A Family Study of Polycythemia Rubra Vera as a Mendelian Dominant Trait."—Dr. John B. Harley.

"The Chemotherapy of Childhood Solid Tumors."—Dr. Barbara Jones.

Doctor Warden Honored

Dr. Herbert E. Warden, professor of surgery, has been elected a founder of The Society of Thoracic Surgeons. The Society, organized in 1964, is dedicated to the pursuit of research and clinical knowledge dealing with lung and cardiovascular surgery.

Doctor Warden joined the WVU faculty in 1960, coming from the University of Minnesota.

869 Students Enrolled

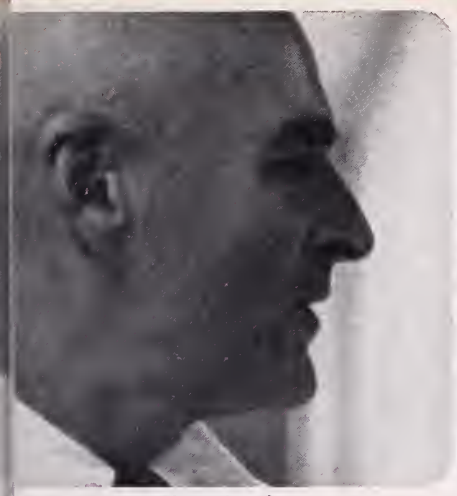
Students from all but one of West Virginia's counties were enrolled in educational programs at the WVU Medical Center during the first semester of the 1964-65 year.

Dr. Kenneth E. Penrod, vice president in charge of the Medical Center, said students came from 54 counties, 22 other states, the District of Columbia and four other countries.

Five counties furnishing the most students were Kanawha (90), Monongalia (77), Marion (41), Harrison (40), and Ohio (29).

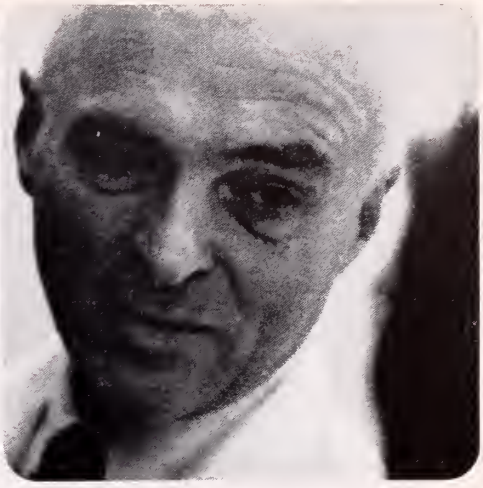
Pennsylvania had the highest number of students from another state. Countries represented were Cuba, India, Liberia and the Philippines.

In all, 869 students were enrolled in the Center's programs of dentistry, medicine, pharmacy, nursing, dental hygiene, medical technology and five graduate programs in the basic sciences. This was an increase of 144 over last year's enrollment for the first semester.



y you a cup of coffee?

Fine! This last patient...

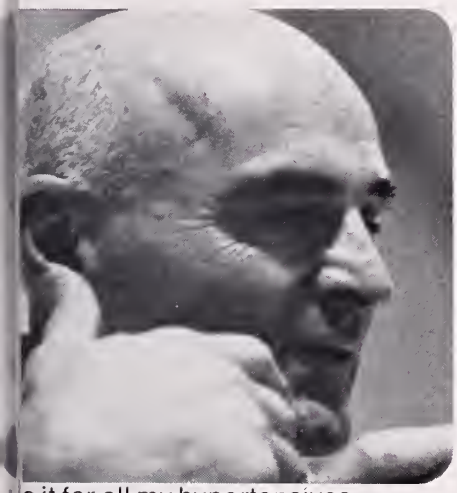


Mrs. Jones?

s, sir. She's down to 140/85.

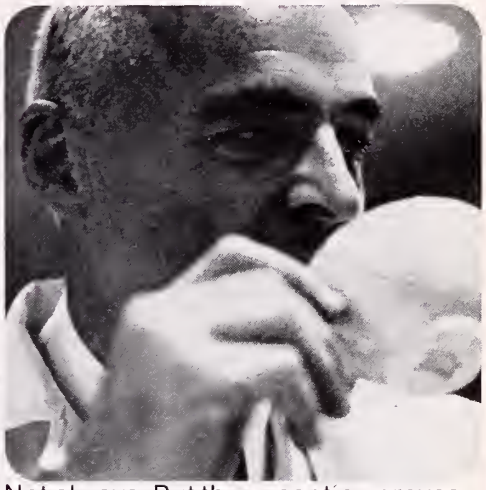
Right. When we started, she was 195/120.

Is that Regroton again?



e it for all my hypertensives.

Does Regroton always work this well?



Not always. But the exception proves the rule.

position: Each tablet contains chlorthalidone, g., and reserpine, 0.25 mg.
raindications: History of mental depression, rsensitivity, and most cases of severe renal epatic diseases.
ning: Discontinue 2 weeks before general thesia, 1 week before electroshock therapy, f depression or peptic ulcer occurs.
autions: Reduce dosage of concomitant anti-rtensive agents by one-half. Discontinue if BUN rises or liver dysfunction is aggravated. trolyte imbalance and potassium depletion occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Availability: Bottles of 100 and 1000 tablets.
Average Dosage: One tablet daily with breakfast.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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Regroton® outperformed other antihypertensives in 95% of patients*

Geigy

The Month in Washington

THE American Medical Association has urged that Congress approve the Herlong-Curtis Eldercare bill (H.R. 3727) as the best answer to the problem of providing medical care to people over 65 who need help in paying hospital and doctor bills.

In testimony presented at a closed hearing of the House Ways and Means Committee, representatives of the AMA also reaffirmed the Association's opposition to the King-Anderson bill, known as Medicare.

The Herlong-Curtis Eldercare bill, incorporating recommendations of the AMA, was introduced by Rep. A. Sydney Herlong, Jr., (D.-Fla.) and Rep. Thomas B. Curtis (R.,Mo.).

The AMA was represented before the House Committee by Donovan F. Ward, M. D., Dubuque, Iowa, the Association's President; F. J. L. Blasingame, M. D., AMA Executive Vice President, and Frank Coleman, M. D., Des Moines, Iowa, Past Chairman of the AMA Council on Legislative Activities.

The bi-partisan Herlong-Curtis bill, entitled the Eldercare Act of 1965, would amend the Kerr-Mills law to authorize broad health insurance coverage for elderly persons. It would authorize federal grants to the states on a matching basis to help persons 65 years of age and older pay costs of the health insurance if they could not afford it otherwise. The bill would provide for utilization of Blue Shield and Blue Cross plans and private health insurance companies.

Cost of Coverage

The cost of such coverage would be borne entirely by government for those elderly individuals whose income falls below limits set by each state. For individuals with incomes between the minimum and a maximum, government would pay a part of the cost on a sliding scale according to income. Individuals with income above the maximum would pay the entire cost, but they would have the benefits of an income tax deduction for such payments, as well as statewide bargaining for non-cancellable health care policies.

Persons under 65 years of age also would be given an income tax deduction for the amount of premiums paid on non-cancellable health insurance policies to become effective upon retirement.

States could administer the program under state health departments if they so chose. The Kerr-Mills program now is administered by state welfare departments.

Both Herlong and Curtis are members of the Ways and Means Committee which made health-care-for-the-elderly legislation its first business of this session.

• **From the Washington Office of the American Medical Association.**

'Helping Those Who Need Help'

In a joint statement when they introduced the bill, Herlong and Curtis said:

"Our legislation is designed to provide elderly persons all the medical services they require, in contrast to the limited benefits in the King-Anderson social security tax bill. Under our bill, workers could not be taxed to pay for hospitalization of those who are financially able to pay for it themselves.

"This legislation would not endanger the solvency of the social security fund or permit control of local hospitals by a federal bureaucracy, as the King-Anderson proposal could.

"This bill goes to the real problem: helping those who need help in financing their health care. That problem would still remain after these individuals had used up the limited benefits of the King-Anderson bill. Why levy a new tax and set up another federal bureaucracy when it will not do the full job?"

The AMA representatives pointed out that the Eldercare bill was designed to provide the elderly who need financial assistance with a wide range of hospital and medical benefits—far more than the limited benefits Medicare would provide.

Under the Herlong-Curtis Eldercare bill, the amount of financial assistance given to the elderly would be determined by the amount of help required, the AMA noted.

The Eldercare plan would expand and enlarge on the existing Kerr-Mills law, preserving state control over administration and requiring no new payroll taxes on wage earners, the AMA said.

They pointed out that Medicare benefits would be restricted to limited hospitalization, some nursing home care in some nursing homes, some hospital-connected diagnostic services, and home nursing care.

They said all these benefits would be provided under the Eldercare program. But in addition, they said, Eldercare would provide the services of physicians and surgeons, drugs outside the hospital as well as in the hospital, diagnostic services whether connected to hospitalization or not, and other medical services which Medicare would not provide.

County Societies

CABELL

The regular monthly meeting of the Cabell County Medical Society was held at the Hotel Frederick in Huntington on January 14. The meeting was called to order by the retiring president, Dr. C. H. Boso, who then turned the meeting over to Dr. C. A. Hoffman, Chairman of the Insurance Committee.

Doctor Hoffman introduced the guest speaker, Mr. Charles Gates, Vice-President and Trust Officer of the Charleston National Bank. Mr. Gates presented an outline of the State Medical Association's new retirement investment program (Wes Trust Plan). Mr. J. Banks Shepherd, administrator of the Association's group insurance programs, also discussed the new plan.

Dr. Walter R. Wilkinson was installed as President of the Society and he presented a plaque to Doctor Boso as a token of appreciation from the Society.

Dr. Gerald Vanston was elected to membership in the Society and Dr. C. O. Reynolds was elected to honorary life membership.—Harold N. Kagan, M. D., Secretary.

* * * *

FAYETTE

Dr. I. E. Buff of Charleston was the guest speaker at the regular monthly meeting of the Fayette County Medical Society which was held at the White Oak Country Club in Oak Hill on February 3.

Doctor Buff presented a paper on "Air Pollution and Heart Disease" and he also presented a film and slides concerning conditions in the State. A lengthy question and answer period followed.

There was a business session following the scientific program and bills pending in the State Legislature were discussed.—W. P. Bittinger, M. D., Secretary.

* * * *

MERCER

Dr. J. E. Blaydes, Jr., was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on January 18.

Doctor Blaydes presented an interesting paper on "Fractures about the Orbit and Other Interesting Eye Lesions." He also showed color slides of other interesting cases including carcinoma of the globe, ptosis, neofibroma of the globe and hemangioma of the lid.

Dr. Sam Milchin, the President, presided at the business meeting. Dr. Henry F. Warden, Jr., presented a brief report on legislation pending on the state and national levels, and Dr. Jean Neilson discussed anti-poverty and Appalachia bills now under consideration by Congress.—John J. Mahood, M. D., Secretary.

If fifty million people say a foolish thing, it is still a foolish thing.—Anatole France.

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HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held a guest dinner meeting at the Stonewall Jackson Hotel in Clarksburg on February 4.

Mrs. Lynwood D. Zinn, Chairman of the Rural Health Committee, presented a film, "The One Who Heals," which was produced by the AMA Department of Medicine and Religion. The film portrayed the relationship of the physician and clergyman working collectively for the benefit of the patient.

Following the film, the Rev. William A. Arthur, Assistant Minister of the First Presbyterian Church in Clarksburg, commented on the clinical training now popular in theological education. He stated, "religion and medicine has worked hand in hand through the ages from the healing miracles of Christ to our Church built hospitals and today's dedicated doctors and ministers."

Mrs. John D. H. Wilson, the President, presided at the business session.—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

RALEIGH

Dr. Warren D. Elliott was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society which was held at the Beckley Hotel in that city on January 19.

Doctor Elliott, who is president of the Raleigh County Medical Society, discussed "Problems of Youth"—a new project the Society and Auxiliary will initiate during the coming year.

Doctor Elliott said that a seven-member planning committee had been established to make a study of the problems of young people in Raleigh County and that area. He said that the committee hopes to establish a moral code. not only for youth, but also for parents.

Prescription drugs are among the few commodities that have actually declined in wholesale prices during recent years. Since 1949 the wholesale prices of specialty prescription drugs declined 12.9 per cent, while the wholesale prices for all commodities measured by the U. S. Bureau of Labor Statistics rose 28 per cent.

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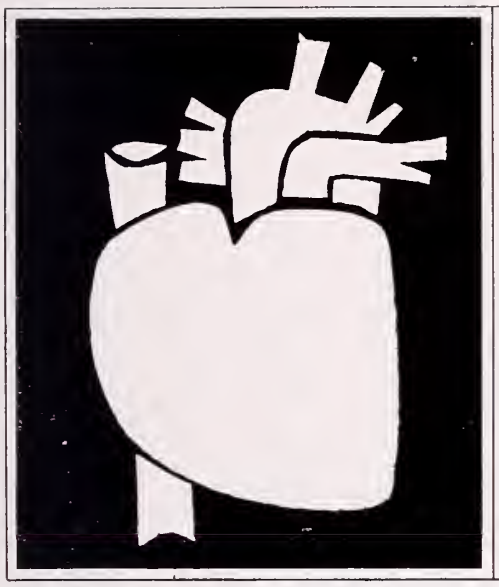

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Book Reviews

SCINTILLATION SCANNING IN CLINICAL MEDICINE—By James L. Quinn, III, M. D., Editor, Assistant Professor of Radiology, Northwestern University School of Medicine; Director of Nuclear Medicine, Chicago Wesley Memorial Hospital. Formerly Chief, Nuclear Medicine Service, The Bowman Gray School of Medicine. Pp. 278. Illustrated. W. B. Saunders Company, Philadelphia, London. 1964. Price $11.50.

This excellent small book is based on a symposium held by the Bowman-Gray School of Medicine early in 1964. The editor, James L. Quinn, M. D., has done an exemplary job of gathering together the various material given at this symposium and presenting it in a comprehensive manner.

This book presents contributions of the foremost workers in this rapidly growing field of medicine. As is inevitable in this type of study, there is some investigational work presented which may not prove to be of significant value. There is also a great deal of background material, leading to the development of specific scanning techniques, which is not of significant value to anyone except investigative workers. However, most of this book is concerned with excellent clinical material.

The fundamental physical consideration of scanning, as well as the radiopharmaceutical properties of scanning materials is well presented. There is an excellent chapter on thyroid scanning, demonstrating the latest clinical and technical concepts of this very important field. There are several chapters on the diagnosis of intracranial tumors which elucidate the extreme value of this technique in many neurological problems. The chapters on renal scanning are also informative.

These collected papers on radioactive scanning do afford a compact and ready reference to currently available methods. Although it was intended primarily for physicians practicing nuclear medicine, this book should be of great value to all physicians interested in radioactive isotopes.—William J. Howland, M. D.

* * * *

A MARRIAGE MANUAL FOR CATHOLICS—By William A. Lynch, M. D.; Trident Press, New York. Pp. 359. 1964. Price $4.95.

Before even looking at the first chapter of this book I was of the opinion that any review of literature dealing with sectarian tenets and dogma should be written by a person of that particular faith. It is only just and honest that any informed person should agree with the basic philosophy of that most noble of all institutions—marriage—which is founded upon a firm belief in God and his solicitude for his children, but I cannot wholly agree that there should exist a Catholic concept of marriage as different from the fundamentals of Jewish, Protestant or Moslem faith. All of us are conceived, born, live and die under the same common biological conditions, and for that reason I can accept the author's basic discussion of marital partner selection, courtship and the simple, yet complex facts of love and life.

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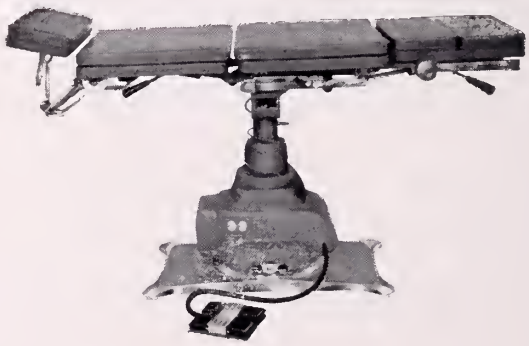

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References: **(1)** Warres, H. L.: *Missouri Med.* 61:27, Jan., 1964. **(2)** Palmer, K. J.: *Week. Urol. Clin. Letter* vol. 6, no. 36, Dec. 24, 1962. **(3)** Carroll, G.: *J. Urol.* 90:476, Oct., 1963. **(4)** Ward-McQuaid, J. F. N. C.; Jichlinski, D., and Macis, R.: *Brit. M. J.* 2:1311, Nov. 23, 1963.

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When we come to the discussion of family limitation and contraceptive methods, my mental path diverges sharply from that of Doctor Lynch. I respect his beliefs and opinions, and those of every sincere adherent of Roman dogma, but I just cannot agree with his concept of what is moral and what is immoral in the field of contraceptive techniques. Perhaps this chapter should have been written in 1966, when the current ecumenical sessions might well have reached some common ground in the solution of such problems. As far back as 1934 I have had considerable experience in contraceptive clinics and, even at that early date, our case load was divided into three groups of roughly equal size—Catholic, Jewish and Protestant.

Anyway, the good doctor and I agree on one statement made on page 138. Dr. Lynch said, "The honeymoon is a valuable and wonderful institution. It is here to stay. We are in favor if it."

Speaking entirely in retrospection, I fully agree with the joys and surprises of a honeymoon.

This is a well-written book. Read it.—James S. Klumpp, M. D.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

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Health insurance protects 48 million more Americans today than it did 10 years ago, the Health Insurance Institute reported recently.

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In 1953, nearly 81 million Americans had surgical expense insurance, but in the following 10 years there was a 67 per cent increase in this coverage and at the end of 1963 nearly 135 million persons had protection against the cost of surgical bills.

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Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures and the course will include trips to demonstration clinics and treatment centers.

The fee for the course is $290 and registration will be limited. Further information may be obtained by writing the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612.

The brain is a part of the human mechanism that begins to function at birth and stops when its owner gets up to make an impromptu speech.—The New Physician.

The nature of men is always the same; it is their habits that separate them.—Confucius.

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I have yet to see any desk-bound administrator or full-time politician who knows as much about the needs of a body as does the person who attends that body on an individual basis hour after hour.

Concern and caution are advisable, of course, for all-drug maker, drug prescriber, drug dispenser and drug user. But when lay judgment is substituted for professional judgment, when the sick refuse to take what is widely prescribed, when consumer representatives and motivation hunters try to resolve medical problems without medical knowledge when the medical profession is notified of government interventions in drug use through the popular press rather than through normal professional channels, when the public receives medical information about drug reactions before the profession is informed, the already ailing members of the public will suffer even more.

In fact, they will suffer more than any other group since it will be their own bodies which are deprived of needed medical counseling and remedies.—Austin Smith, M. D., in Oklahoma Medical Journal.

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GENERAL PRACTITIONER—Urgent need and excellent opportunity for general practitioner. Solo practice or association with established young GP in Berkeley Springs, W. Va. A clean, progressive, small town within easy driving distance of Washington, Baltimore and Winchester. 60-bed modern hospital. Office space, housing and financial help available. Above average income. Contact C. A. Burgess, M. D., 1090 Fairfax Street, or Robert L. Hale, War Memorial Hospital, Berkeley Springs, W. Va.

WANTED—General practitioner for small community and large surrounding farming area—near coal mines. Good roads and modern conveniences. Retired physician with fifty years experience in general practice and the citizens are interested in helping a physician and believe that the locality offers many advantages. Contact Dr. A. O. Kelly, Wallace, W. Va. Phone 796-3910.

HOUSE PHYSICIANS WANTED—Two openings in a general hospital with 150 beds. Salary open, commensurate with qualifications of applicant. Interview desired and will reimburse one-way fare for same. Write DOD, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324

PHYSICIAN WANTED — An experienced general practitioner to add to and work with an established salaried group in metropolitan area. This provides regular hours and minimal night work. Contact Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302.

WANTED—General practitioner for modern 40-bed accredited hospital. Chief of Staff will offer office space and/or partnership to a qualified and ambitious physician. Growing industrial community of 2500 citizens, with a drawing area of approximately 10,000. Located in the beautiful South Branch of the Potomac—the heartland of West Virginia's recreational area. Write Mr. Robert G. Via, Administrator, Hampshire Memorial Hospital, Romney, W. Va.; or phone collect 737.

GENERAL SURGEON—Additional general surgeon needed. F.A.C.S. preferred. Rural community with excellent hospital facilities. Write BBB, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

ANESTHESIOLOGIST — Seeking new location in small community. Training received at well-known New England clinic. Ten years experience with large city group. Write POK, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

HOUSE PHYSICIAN WANTED—Opening in a new 42-bed hospital. Salary open and good working conditions. Write CCC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

FOR SALE—X-ray and Fluoroscope in good working condition. Write LLL, West Virginia Medical Journal, Box 1031, Charleston, W. Va.

AVAILABLE—Board eligible OB-GYN specialist; 30 years of age, married and 2 children. Residency training at Philadelphia General Hospital and currently completing service obligation. Available in August, 1965 and interested in association or group practice in West Virginia. Write BMT, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Physicians needed to take over established practice of deceased physician. Modern office available in community located in Southern West Virginia. Trading population of 75,000. Splendid opportunity for one or more physicians. Contact BLW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Anesthesiologist desires to locate in West Virginia upon completion of training in June, 1965. Nine years experience in general practice. Foreign graduate and licensed in West Virginia. Write LAC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Full-time director for emergency room of 300-bed hospital. Duties to include supervision of the emergency room activities of the house staff—currently numbering 26 interns and residents. Must be eligible for licensure; salary open. Contact D. Hamaty, M. D., Director of Medical Education, Memorial Hospital, 3200 Noyes Avenue, S. E., Charleston, West Virginia.

WANTED—General practitioner for large, modern coal mines in southern West Virginia. A splendid opportunity for an energetic practitioner. Write GAC, The West Virginia Medical Journal, Box 1031, Charleston 24.

PHYSICIAN WANTED—Physician trained in obstetrics or with special interest in obstetrics to do mostly obstetrics and some general practice in association with qualified man in group. Excellent guarantee and a good future. Write NNN, The West Virginia Medical Journal, Box 1031, Charleston, W. Va.

WANTED—General practitioner in Richwood. Citizens of this community are interested in helping physician and believe that the locality can offer an ambitious doctor many advantages. Contact Sr. M. Pia, C.M.P., Administrator, Sacred Heart Hospital, Richwood, W. Va.

INTERNIST NEEDED — Services of an internist needed in fast growing community. Excellent hospital facilities and office space available. Write TMB, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Physician for staff position in medical department of Union Carbide Corporation Chemical Plant with approximately 4,000 employees. Liberal benefits; salary commensurate with experience and qualifications; State license required; age limit 65. Write to E. Q. Hull, M. D., Medical Director, Post Office Box 8004, South Charleston, W. Va. 25303.

WANTED—Two general practitioners to locate in the vicinity of Hundred, W. Va., which includes a large area and good advantages. Write Mrs. Mary Mike, Route 1, Burton, W. Va.

WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031, Charleston W. Va. 25324.

WANTED—General practitioner, pediatrician, internist and board certified surgeon for community on Ohio River. New 40-bed hospital in industrial community. Write RAO, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

The West Virginia Medical Journal

April, 1965 Vol. 61, No. 4

Amniotic Fluid Embolism*

(Report of Five Cases from the Files of the Maternal Welfare Committee of the West Virginia State Medical Association, And an Additional Fatal Case)

Marion S. Brown, M. D.

Amniotic fluid embolism as a clinical entity was first described by Meyer,[15] in 1926. Steiner and Luschbaugh,[21] in 1941, followed with a full account of the clinical syndrome and of their experimental reproduction in dogs. With these two reports the medical literature begins its description of this important obstetric complication and, since the 1940's, reports have grown in frequency. The latest review of the literature was published in October, 1962, by Aguillon et al,[1] who account for 73 proven cases through 1957.

Incidence

Statistics vary in different areas regarding incidence of the disease. The highest record comes from the Minnesota State Maternal Welfare Committee[2] in which 15 of 234 obstetric deaths (6.4 per cent) were reported attributable to this cause, and the disease ranked fifth in the causes of obstetric deaths, thus: (1) hemorrhage, (2) toxemia, (3) infection and (4) heart disease. A maternal mortality review from Chicago for the years 1956-1960[13] revealed 3 of 146 obstetric deaths, or 2.1 per cent. In the state of Ohio for the years 1955-1959, there were 11 of 408 (2.7 per cent.)[2] From Dallas there were only two proven cases prior to 1959.[1] In the Charity Hospital in New Orleans there were no deaths from this cause during the period 1942 through 1951.[2]

We could ask: Is the disease relatively new? Is it on the increase? We have not seen these questions answered, but it is of more than passing significance to note that in the area giving the report of the highest incidence, 50 per cent of cases occurred in patients who had received pitocin during labor.

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Submitted to the Publication Committee, July 31, 1964.

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Symptomotology

In a typical case the patient will manifest the following: A complaint of feeling cold, or a chill; dyspnea; dusky pallor proceeding to cyanosis; markedly increased respiratory rate; tachycardia; pulmonary edema (not always); absence of chest pain (usually); increased restlessness which may become violent; loss of normal cooperation and communication contact ("in a trance"[5]); hemorrhagic diathesis (may or may not be present); shock (may or may not develop); coma; renal failure to some degree may develop if patient survives long enough; slow improvement over a period of from 5 to 14 days; sudden or very early death.

Diagnosis

Diagnosis will be based on the following:

1. Symptomatology and course. Quoting Scott:[20] "Unexplained cardiopulmonary collapse is the most prominent feature."
   a. Physical examination: Significant chest findings for which the clinician should be alert include pulmonary edema; accentuated and split P_2 sound, significant of pulmonary hypertension.

2. Pertinent laboratory data may include:
   a. Clot formation or lysis, or both.
   b. Hematocrit.
   c. Fibrinogen level.
   d. Renal function, e.g., specific gravity; recorded output; urea nitrogen.
   e. Chest film and electrocardiogram: Significant changes have been recorded in both 4 hours after onset of symptoms of embolization.[10]
3. Aspiration of blood from the right heart and centrifuging, after the method of Gross and Benz.[9] In these cases the blood has been observed to settle into three layers instead of the usual two. In the top layer amniotic fluid ingredients are found. This method has been reported to have been used antemortem, but not successfully. It should be, however, a routine part of autopsy examination in suspected cases, necessitating very prompt performance of postmortem examination.
4. Autopsy: Until very recently the diagnosis has never been considered to be established by means other than autopsy findings.[2] These include:
   a. Amniotic fluid particulate matter (meconium, mucin, lanugo hairs, squamous cells from the amnion) in vessels of the lungs, myometrium, placenta and, occasionally, other organs, and in blood aspirated from the inferior vena cava or right heart and examined as described above. Special staining usually is required to identify these substances, including mucin stains and, for the squamous structures, the Papanicalaou stain.
   b. If hemorrhagic diathesis has been present, petechial hemorrhages will be found in various organs.
   c. Pulmonary edema of varying degree frequently is seen.
   d. Enlargement of the right heart.
   e. Pituitary necrosis may be present.[7]

   Of these only a. is pathognomonic.

Etiology and Pathogenesis

The initial etiology of this disease must be the entrance of amniotic fluid and, with it, particulate matter, into the maternal circulation. The variously accepted mechanisms by which this may occur are as follows:

1. A uteroplacental defect must obviously be present, and may result from:
   a. Very hard labor.
   b. A rent in uterine sinusoids or cervical veins.[16]
   c. Amnioplacental defect, with dissection of amniotic fluid into amnio-chorionic space. Hellman et al[12] have shown that amniotic fluid pressure exceeds intervillous space pressure slightly for a short interval in early systole during normal uterine contractions in human subjects.
2. These conditions may be found in increased frequency in:
   a. Injudicious use of oxytocics.
   b. Multiparity.
   c. Abruptio placentae.
   d. Uterine rupture, particularly in the lower uterine segment.
   e. Direct incision at cesarean section.

Barno and Freeman[2] have expressed conclusions regarding the possible mechanisms involved as follows: "The one common denominator in this disease seems to be tumultuous labor or exceptionally strong uterine contractions." (In their report of the Minnesota series this was present in 14 of 15 cases, and in 50 per cent of these the patient had received pitocin during labor). "The careless use of this drug, therefore, must be implicated in the etiology of this disease."[2]

The pathologic physiology involved in the sequelea in the cardiopulmonary system has been documented experimentally by Halmagyi et al[11] in work done on sheep in which the identical clinical picture was produced and the following changes observed: (1) pulmonary hypertension and (2) fall in lung compliance. Lung compliance, or the relative ease with which pressure will distend the lungs, is decreased approximately in proportion to the amount of lung excluded. Distensible units may be reduced by alveolar transudate when pulmonary edema is present. In the absence of edema there is a reactive constriction of the musculature of unsupported airways distal to the embolism, with exclusion of the more peripheral alveoli from expansion. Nickerson[16] names anaphylaxis with previous sensitization as a possible mechanism in the pulmonary crisis and, for a time, predominance of multiparae might seem to bear this out although statistics now reveal a substantial number of primigravidous patients.

A coagulation defect is reported in the blood of less than half of all cases. The two schools of

thought[6, 8, 14, 17, 18, 19] regarding the development of this phenomenon are:

(1) Hyperplasminemia with accelerated fibrinolysis which overwhelms the inhibiting system.

(2) Intravascular microcoagulation to the depletion of available fibrinogen.

These two mechanisms are spoken of respectively as primary and secondary fibrinolysis. The resulting products of fibrinogen proteolysis "also contribute to the coagulation defect by leading to defective fibrin polymerization."[8]

Treatment

In this dramatic clinical syndrome the best treatment still is the age-old maxim: prophylaxis. This is best attained by the judicious use of oxytocic drugs. And as in any critical emergency, treatment is facilitated greatly by early diagnosis which is dependent on familiarity with the syndrome and vigilant suspicion. Further active recommended therapeutic measures include:

(1) Oxygen under positive pressure transmitted through a defoaming agent if pulmonary edema is present.

(2) Semi-Fowler position.

(3) Judicious limitation of intravenous fluids.

(4) Rotating tourniquets on 3 of the 4 extremities in succession to reduce venous return to the right heart.

(5) Digitalization.

(6) Aminophyllin for bronchiolar spasm.

(7) Fibrinogen and blood replacement when a coagulation defect exists.

(8) Vasopressors as an adjunct to blood replacement.

(9) Morphine to relieve dyspnea and apprehension.

(10) Atropine and papavarine to reduce pulmonary vascular spasm.

Therapeutic measures which have been used experimentally and which may find clinical application also include:

(1) Halmagyi[11] found that the use of isoproterenol (Isuprel-Winthrop) in sheep would reverse or prevent constriction of bronchiolar musculature when pulmonary edema was not present. The agent was effective when given either by aerosol inhalation or intravenous infusion.

(2) A coagulation defect in which abnormal fibrinolysis is present has been observed experimentally to be controlled by the administration of epsilon-amino-caproic acid which is a specific plasminogen activator antagonist. As yet the toxic effects of this agent have not been controlled nor has provision been made against the damage of possible interference with lysis of thrombi in vital structures.[8, 18, 19] (Since this manuscript was submitted epsilon-amini-caprioc acid has appeared on the market as Amicar (Lederle).

Prognosis

Maternal.—In Aguillon's review,[1] analysis of 65 cases revealed an 83 per cent maternal mortality rate. Until recently the condition has been considered almost uniformly fatal and classified by maternal welfare committees as unpreventable. With the increasing number of descriptions of apparently well documented recovered cases,[20] however, it is strongly suggested that the severity of the disease may be a matter of degree, presumably dependent on the quantity of particulate amniotic matter released into maternal circulation, also that many unrecognized cases may go undiagnosed and recover.

Newborn.—The 26 infants who survived in the Aguillon[1] report represent a 40 per cent survival, and two of these were delivered by postmortem cesarean section. We have seen no study of the surviving infants. In our case the baby had hyaline pulmonary disease, but survived. A review of these surviving infants would be most interesting and informative.

West Virginia Case Reports

The following are reports of 5 cases of fatal amniotic fluid infusion from the files of the Maternal Welfare Committee of the West Virginia State Medical Association between the years 1953 and 1962.

Case 1.—A 25-year-old para 3003 was admitted 2 hours after onset of very active labor, at 4 P.M., December 21, 1953, which was her ECD. At 7:40 P.M. she was delivered spontaneously of a 10-pound, 12-ounce infant under a very short gas-oxygen-ether anesthetic. With the delivery of the head, the patient vomited and aspirated a portion of vomitus. During the ensuing short period of intensive treatment a bronchoscope was passed twice and airways aspirated. She died 3 hours postpartum.

Autopsy.—Amniotic fluid infusion into pulmonary vessels was found in addition to food particles in terminal bronchioles which were surrounded by pus cells. There was diffuse associated bronchopneumonia.

Committee Comment.—The case was classified as unpreventable in a letter dated April 23, 1954.

Case 2.—Para 1001 was admitted on March 26, 1958, during the 28th week of gestation, with ECD June 20, 1958, for treatment of a severe upper respiratory infection which had failed to respond to treatment at home. Hospital diagnosis was bilateral bronchopneumonia, probably viral. Antibiotic therapy was used. The patient showed improvement. Early in the morning of the third hospital day, sudden dyspnea, cyanosis, delirium and uterine contractions developed. The cervix was uneffaced and undilated. The clinical impression was anoxic uterine contractions. Treatment was supportive. The patient died at 1:30 P.M. on March 29, 1958.

Autopsy.—Pulmonary edema. Multiple amniotic fluid emboli. Early bronchopneumonia. No point of entrance of amniotic fluid into maternal circulation could be determined. There was no evidence of placental separation nor of puerperal infection.

Committee Comment.—Classified nonpreventable, as no factors of preventability were found.

Case 3.—A 39-year-old para 15-0-2-15 was first admitted on December 27, 1958, approaching term. Vaginal bleeding was present; anemia was severe; no fetal heart was heard; uterine contractions were present. Treatment included 1,500 cc. of whole blood. Contractions and bleeding ceased. On the third hospital day, with hemoglobin of 10.9 Gm. and serum fibrinogen 550 mg. per cent, the patient was discharged.

She was readmitted January 2, 1959, with a pink discharge and back pain. She was observed for 4 days. On January 6, 1959, induction of labor was begun by giving pitocin mm. 0.5 subcutaneously every 30 minutes for 4 doses. At 3:07 A.M. spontaneous amniotomy occurred, and at 3:15 A.M. she was delivered spontaneously by the intern of a living fetus with multiple deformities and weighing 6 pounds, 6-1/2 ounces. The fetus expired after 20 minutes as a result of its deformities.

Summary of maternal labor: 1st stage 8 1/2 hours; 2nd stage 45 minutes; 3rd stage 1 minute. Analgesia: Nembutal grains 6, 3 3/4 hours before delivery. Anesthesia: Nitrous oxide and oxygen for 20 minutes, given by nurse. Fourth stage: Ergonovine 2 cc. I.V. Good uterine contractions. Four minutes after delivery of the placenta the patient suddenly became cyanotic; respirations were slow and shallow; no pulse nor B.P. was obtained. Treatment consisted of plasma, whole blood and stimulants. The obstetrician arrived 45 minutes after delivery. His clinical impression was amniotic fluid embolism. Test tube blood clotted and soon reliquified. Profuse vaginal bleeding occurred. Examination revealed no lacerations. Fibrinogen was given. The patient expired 3 1/4 hours postpartum.

Autopsy.—Refused.

Committee Comment. — Blood should have been drawn from right heart to aid in diagnosis though autopsy was refused. Induction of labor was not indicated. Pitocin contraindicated in grandmultiparity.

Case 4.—A 35-year-old para 0111 was admitted on June 9, 1961, in the 37th week of uterine gestation, with preeclampsia. She was edematous, with B.P. 160/106 but no albuminuria was present. Amniotomy was performed on admission. On June 10, 1961, a pitocin infusion was begun, using 1 ampule of pitocin in 500 c.c. of 5 per cent glucose in water. On June 11, 1961, a similar infusion was repeated for 2 hours. FHT 140. B.P. 124/80. On June 12, 1961, the same infusion was used for 2 1/2 hours. First stage of labor was established by 9:20 P.M., and became severe by 1 A.M. the next day. Analgesia: Nisentil 40 mg. and scopolamine 0.4 mg. At 4:32 A.M. a 6-pound, 4-ounce newborn was delivered with outlet forceps, with episiotomy and no lacerations. Anesthesia: Nitrous oxide and oxygen for 20 minutes by an M.D. B.P. 120/80; maternal pulse 120. In the third stage ergotrate 1/320th grain was given I.V. Placenta delivered intact at 4:38 A.M. Thereafter the ergotrate was repeated I.V. One minute after delivery of the placenta the patient suddenly became cyanotic. The B.P. fell to 60/0, and pulse rose to 180. Six minutes later pitocin infusion was begun, using 1 cc. pitocin in 1,000 cc. of glucose in water. Additional therapy included neosynephrine, whole blood, fibrinogen, solu-cortef and, finally, supravaginal hysterectomy which was completed 4 hours postpartum, and the patient died 15 minutes later.

Autopsy.—Lungs: Many small vessels contained fibrinoid material and trophoblastic cells. Some alveolar walls were broken. One bronchus showed loose squamous cells in its lumen. Adrenals: Both were 3 times normal size, with hemorrhage replacing the medulla and most of the cortex. Uterus: Small fibrinoid masses were present in small vessels and sinuses of the cervical segment. Hydrothorax and ascites were present.

Committee Comment.—Classified as preventable, with injudicious use of pitocin after amniotomy.

Case 5.—The patient was a para 4115, admitted on December 31, 1961, with ruptured membranes, not in labor, in the 39th week of gestation. She had a history of hemorrhage requiring transfusion following 3 of 4 previous term pregnancies, and following an abortion. The cervix was intact and presenting part was floating. Amniotic fluid was clear and odorless. She was observed only, until January 3, 1962, when fever and chills developed, with productive cough and no pyuria. Treatment was aureomycin. Labor began spontaneously. First and second stages of labor were uneventful. A completely flaccid 5-pound, 13-ounce newborn was delivered under oxygen inhalation only; APGAR 4; successfully resuscitated with intubation; died after 14 days, with autopsy diagnosis of congenital meningitis and systemic infection. Maternal third stage of labor was attended with abnormal vaginal bleeding. Pitocin infusion with 2 cc. pitocin in 1,000 cc. of glucose in water was used. Manual removal of the placenta failed in the hands of the attending physician, but was considered successful in the hands of a consultant. The patient's extreme vasomotor collapse was out of proportion to her blood loss. Total third stage was 59 minutes. Treatment included whole blood under pressure, and fibrinogen. The patient died 4 hours postpartum.

Autopsy—Ruptured lower uterine segment with retroperitoneal hematoma; small area of retained placenta; bilateral pulmonary congestion; enteric ascariasis with mesenteric lymphadenitis and focal necrosis of the liver. (No mention was recorded of amniotic infusion.)

Committee Comment.—Classified preventable, with responsibility assigned both to the attending physician and the consultant. Direct cause of death was listed as uterine rupture with rupture of right uterine artery. Contributing causes were given as: afibrinogenemia, bacterial endotoxic shock and amniotic fluid embolism.

Of the foregoing, Case 2 stands out as etiologically unique, suggesting microscopic uteroplacental defect, possibly arising on a cytotoxic basis.

Report of Our Case

The patient was a 23-year-old para 2002, admitted on August 25, 1963, for elective repeat cesarean section scheduled 14 days prior to ECD, September 8, 1963. Her primary cesarean had been done on December 25, 1960, for abruptio placentae. Her second pregnancy had been terminated by elective cesarean 12 days before ECD. Both abdominal deliveries were followed by successful puerperal convalescence. In her first pregnancy, where spontaneous placental abruption occurred at term, she had experienced early gestational bleeding on days 33 and 34 following LNMP. The second pregnancy was uneventful.

In this pregnancy, she again had bleeding from days 43 through 55. This terminated spontaneously, and she remained well throughout her prenatal period. X-ray film of the abdomen taken to rule out multiple pregnancy revealed a teratomatous tumor in the left lower abdomen.

Because this healthy young woman expired as the result of a dramatic acute malady following her third cesarean section on August 26, 1963, an abstract of the events of this date follows:

Premedication: Demerol 50 mg. with atropine 0.4 mg. I. M. Anesthesia: Spinal, using 10 mg. of pontocaine. A 3430 Gm. newborn was delivered 8 minutes after abdominal incision, through a transverse, muscle-splitting trachelotomy. After delivery of the head the operator requested the anesthetist to apply gentle fundal pressure, which he did with a massaging motion. The patient conversed regarding the baby, his sex and name, and then stated that it was difficult for her to get her breath. The anesthetist reported that auscultation of the upper chest was clear. He then induced ethylene-nitrous-oxide-oxygen anesthesia with intravenous pentothal. Syntocinon 1 cc. was given intravenously one minute after delivery of the baby. The placenta was still in situ. A conspicuous bulge 12 cm. in diameter was noted in the left lateral uterine wall as soon as the uterus contracted, which suggested the possibility of an intrauterine teratoma. However, the hand was slipped without resistance along the line of utero-placental cleavage, and the placenta delivered intact with ease from the hollow portion of this bulge, and the bulge disappeared. In retrospect, this finding was considered significant as an area probably related to the process of amniouterine communication, and detailed review of the events of the morning led to the conviction that amniotic infusion must have occurred by the moment of delivery of the placenta at 8:36 A. M. The balance of the operative procedure, i.e., closure of the lower uterine segment, left oophorectomy (dermoid cyst), and abdominal wall closure, became very tedious because of abnormal bleeding. Uterine atony became apparent at once. Over a period of 20 minutes two ampules of pitocin were used intramyometrially and one ampule of adrenosem intra-

muscularly. At the same time blood was drawn from an antecubital vein for serum fibrinogen determination, which later was reported to be 510 mg. per cent. Whole blood was running into the other arm. When the operation was completed at 9:40 A.M., there was no bleeding from vagina or skin. No further abnormal bleeding developed.

At 10:30 A.M., the patient reacted and was normally restless. She was given demerol 100 mg. I. M. by the nurse. At 11 A.M., the nurse noted a nonproductive cough. At 11:30 A.M., the patient stated she felt nauseated and was given Tigan 200 mg. I.M. as per previous order for nausea. At 11:45 A.M., the recovery room nurse phoned the attending obstetrician, stating that the patient's fingernails were cyanotic and her respirations rapid. Fifteen minutes later I found the patient in obvious acute pulmonary edema. Two physicians were standing by, aspirating fluid from the nasopharynx, and administering oxygen. The patient was restless, dyspneic, pale-to-cyanotic, mentally out of touch, and without her normal cooperation. In the next hour and a half two anesthetists, the clinical pathologist and an internist were in attendance in consultation. The following procedures were used: Oxygen endotracheally under positive pressure, after being passed through 85 per cent alcohol as a defoaming agent; endotracheal aspiration; atropine; aminophyllin; additional demerol; rotating tourniquets applied to extremities; hydaltrasol; cedalanid; cardiac pace-maker applied to closed chest wall; coramine. Though peripheral pulse was maintained nearly an hour with the pace-maker, the myocardial response became weaker and the patient was pronounced dead at 1:30 P.M., five hours postpartum, and two hours after cyanosis and abnormal restlessness developed.

Autopsy.—Hydrothorax; voluminous frothy lungs; pulmonary artery and major branches contained no thrombi; heart, its chambers and pericardium grossly normal; both adrenals normal; gravid uterus not unusual; surgical incisions and left ovarian pedicle showed no evidence of bleeding.

Microscopic: Lungs (Figures 1, 2, 3): Small vessels contained fibrin and squamous cells, with marked leukocytic infiltration around these sites; Uterus (Figures 4, 5): Maternal sinusoids in the body of the uterus, but not in cervical sections, revealed amniotic elements.

Analysis of Our Case.—In an attempt to summarize objectively the factors which might have been responsible for the amniotic embolization in this case, I list the following, somewhat in chronologic sequence, and selected in the light of the preceding study of the problem.

A. Those factors which might have initiated the entrance of amniotic material into intervillous spaces, either uterine or cervical:

   1. Uteroplacental anaphylactic tissue reaction with resulting defect, which would have been on a basis of multiparity.

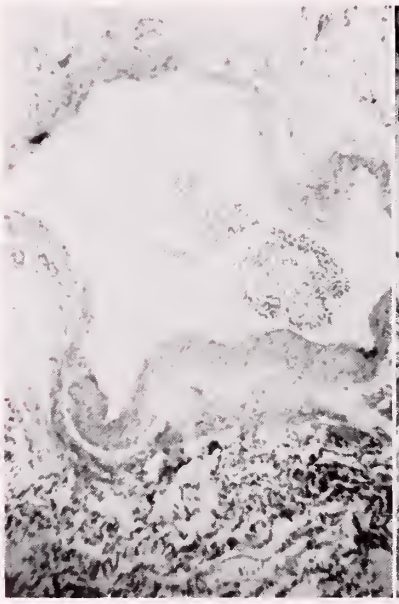

Figure 1

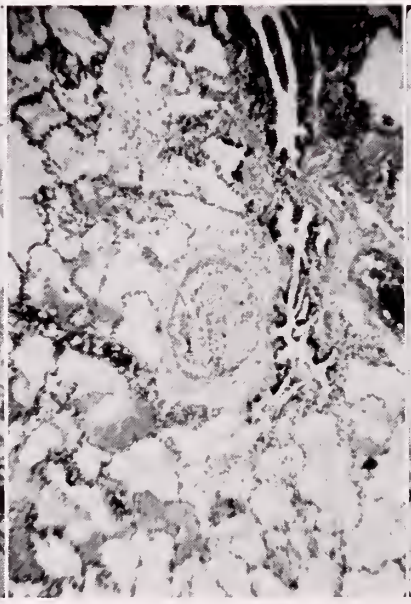

Figure 2

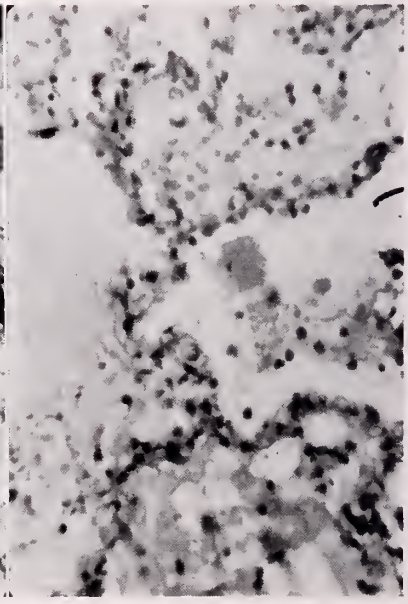

Figure 3

Figure 1. Mucous Debris in Pulmonary Vessel. X-100. Hematoxylin and Eosin. (Figure 2) Desquamated Squames in Peribronchial Vessel. X-35. Hematoxylin and Eosin. (Figure 3) Desquamated Epithelial Cell in Edema Fluid of Pulmonary Alveolus. X-430. Hematoxylin and Eosin.

2. An essential or primary uteroplacental defect represented by the uterine bulge.
3. Possible endocrine or enzymatic deficiency effecting myometrial or decidual integrity (and possibly responsible for factor No. 2), as suggested by early gestational bleeding in her first and third pregnancies, in both of which she experienced uteroplacental accidents at term.
4. Low cervical surgical incision.
5. Fundal massage.
6. Syntocinon 1 cc. I.V. one minute after delivery.

B. Those which may have increased the degree of severity of the disease, by increasing the quantity of amniotic contents released from uterine or cervical sites into the maternal circulation:

1. Use of pitocin following delivery of the placenta.

Conclusions

1. A brief study of the problem of amniotic embolization is presented, with special interest in possible avenues of pathogenesis.
2. Six fatal cases studied by the Maternal Welfare Committee of the West Virginia State Medical Association over a 10-year period are submitted, 5 with abstracts from committee files, and one an additional personal case.
3. A summary of the symptomatology, diagnosis and treatment of this clinical syndrome is given, with special warning regarding injudicious use of oxytocics in labor.
4. Observations are made regarding an increasing number of recovered cases.
5. On all obstetricians rests the responsibility of prompt recognition and immediate appropriate therapy in the presence of this disease entity.

Acknowledgment

The author acknowledges with thanks the assistance of Dr. Charles W. Thacker, Department of Pathology, Camden-Clark Memorial Hospital, Parkersburg, W. Va., in the preparation of the photomicrographs.

References

1. Aguillon, A., Andjus, T., Grayson, A. & Race, G. J.: Amniotic Fluid Embolism: A Review. Obstet. & Gynec. Survey 17:5:619-636 (Oct.) 1962.

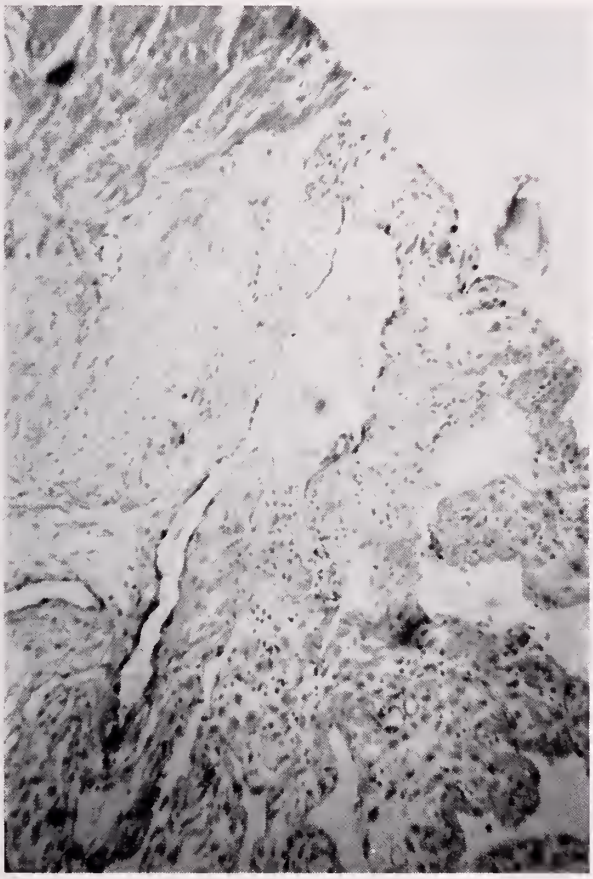

Figure 4

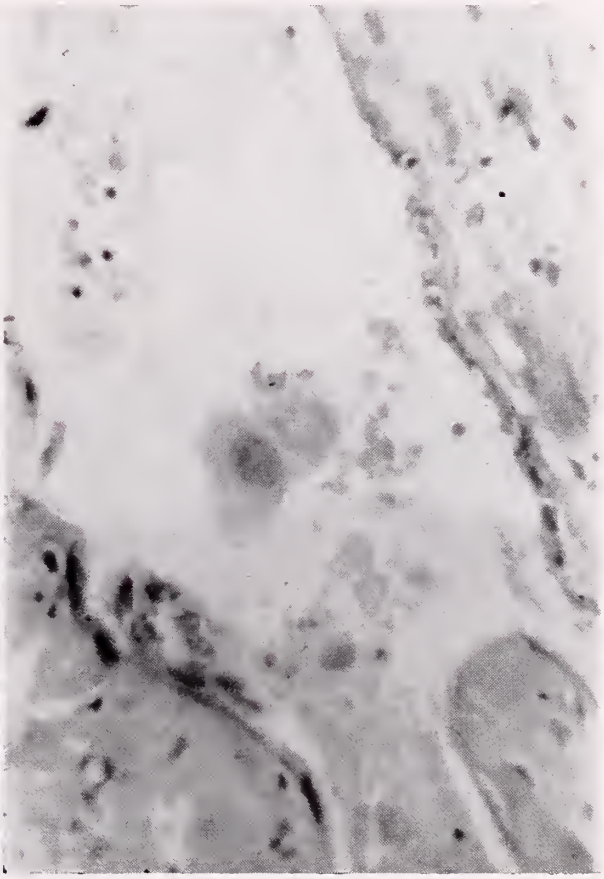

Figure 5

Figure 4. Uterus. Amniotic Debris in Uterine Sinusoid. X-430. Hematoxylin and Eosin. (Figure 5) Uterus. Amniotic Debris in Uterine Sinusoid. X-100. Hematoxylin and Eosin.

2. Barno, A. & Freeman, D. W.: Amniotic Fluid Embolism, Am. J. Obstet. & Gynec. 77:6:1199-1210 (June) 1959.
3. De Lee J. B.: Case of Fatal Hemorrhagic Diathesis With Premature Detachment of Placenta, Am. J. Obst. 44:785, 1901.
4. Diekmann, W. J.: Blood Chemistry and Renal Function in Abruptio Placentae, Am. J. Obst. & Gynec. 31:734, 1936.
5. Finestone, A. J. & Beecham, C. T.: Recovery from Amniotic Fluid Embolism, Hypofibrinogenemia and Acute Renal Failure, Obst. & Gynec. 17:4:486-489 (April) 1961.
6. Fletcher, A. A., Alkjaersig, N. & Sherry, S.: Pathogenesis of Coagulation Defect Developing During Pathologic Plasma Proteolytic (Fibrinolytic) States. II. Significance, Mechanism and Consequences of Defective Fibrin Polymerization, J. Clin. Investigation 41:917, 1962.
7. Gold, E. M. & Librach, S.: Sheehan's Syndrome Following Proved and Treated Afibrinogenemia, Am. J. Obst. & Gynec. 74:1:190-192 (July) 1957.
8. Goldstein, D. P. & Reid, D. E.: Circulating Fibrinolytic Activity: A Precursor of Hypofibrinogenemia Following Fetal Death in Utero, Obst. & Gynec. 22:2:174-180 (August) 1963.
9. Gross, P. & Benz, E. J.: Surg., Gynec. & Obst. 85:315, 1947.
10. Hager, H. F. & Davies, S. D.: Nonfatal Maternal Pulmonary Embolism by Amniotic Fluid, Am. J. Obst. & Gynec. 63:4:901-904 (April) 1952.
11. Halmagyi, D. F. J., Starzecki, B. & Shearman, R. P.: Experimental Amniotic Fluid Embolism and Treatment, Am. J. Obst. & Gynec. 84:2:251-256 (July 15) 1962.
12. Hellman, L. M., Tricomi, V. & Gupta, O.: Pressures in the Human Amniotic Fluid and Intervillous Space, Am. J. Obst. & Gynec. 74:5:1018-1021 (Nov.) 1957.
13. Lane, R. E. & Andelman, S. L.: Maternal Mortality in Chicago 1956 Through 1960, Am. J. Obst. & Gynec. 85:152-169 (Jan. 1) 1963.
14. Latallo, Z. S., Fletcher, A. P., Alkjaerisig, N. & Sherry, S.: Inhibition of Fibrin Polymerization by Fibrinogen Proteolysis Products, Am. J. Physiol. 202:681, 1962.
15. Meyer, J. R.: Embolia Pulmonar Amniocaseosa, Brasil-med. 2:301-303, 1926.
16. Nickerson, D. A.: Amniotic Fluid Embolism, J.A.M.A. 178:7:758-759 (Nov. 18) 1961.
17. Phillips, L. L. & McKay, D. G.: Profibrinolysin Activator in the Rat Placenta, Am. J. Obst. & Gynec. 87:1:56-62.
18. Reid, D. E.: The Acquired Clotting Defect (Hypofibrinogenemia) in Pregnancy: Further Observations. Am. J. Obst. & Gynec. 87:3:344-353.
19. Reid, D. E., Weiner, A. E. & Roby, C. C.: Intravascular Clotting and Afibrinogenemia, the Presumptive Lethal Factors in the Syndrome of Amniotic Fluid Embolism, Am. J. Obst. & Gynec. 66:3:465-474 (Sept.) 1953.
20. Scott, M. M.: Cardiopulmonary Considerations in Nonfatal Amniotic Embolism, J.A.M.A. 183:12:989-993.
21. Steiner, P. E. & Luschbaugh, C. C.: J.A.M.A. 117:1245-1254 & 1340-1345, 1941.
22. Talbert, L. M., Easterling, W. E., Jr., Flowers, C. E., Jr. & Graham, J. B.: Acquired Coagulation Defects of Pregnancy: Including Case of a Patient with Hydatidiform Mole, Obst. & Gynec. 18:69-76 (July) 1961.

The Dangerous Benefits of Modern Drugs

THAT drugs are capable of inducing harm as well as benefits is beyond cavil. Indeed, potential danger appears inherent in all human advances. One need only cite the loss of life incurred by the automobile, and the Sword of Damocles which nuclear energy has suspended over all living matter. However, in considering the toxicity of drugs one should not lose sight of the contribution of these agents to the relief of suffering and to human welfare.

It would be to the disservice of humanity and medicine if we allowed an imbalanced perspective to hamper the advance in drug therapy which has characterized the present century. Full knowledge of the drugs at his disposal rather than restrictive measures controlling their use will enable the physician to derive the great benefits of drug therapy while maintaining at a minimum the harm inherent in their use.—Arthur Grollman, M. D., in Texas State Journal of Medicine.

Duplication of the Stomach*†

A. Kyle Bush, M. D.

GASTRIC duplication is the least common of the intestinal duplications. Green,[1] in 1958, found 28 cases of duplication of the stomach reported in the English literature. Five additional cases have been reported since: 4 by Nissan,[2] in 1960, and 1 by Shelton and Turner,[3] in 1962.

The Author

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Embryology

Numerous theories have been advanced to explain the origin of duplication. One of the regularly repeated theories of the development of intestinal duplication is attributed to Lewis and Thyng[4] who, in 1908, described from the fetal alimentary tract of pigs, rabbits, cats, sheep and human embryos of from 4 to 23 mm. in length, tiny buds of intestinal epithelium protruding into the subepithelial tissue. The buds appear as nodes or nodules and as occasional diverticula. Bremer[5] further expounded on this theory, pointing out that some buds increase in size, become expanded at the distal end, and either remain connected with the lumen by a narrow pedicle or separate and become a closed cyst. When this happens, the outer expansion is limited by the inner circular muscular layer and spread occurs in the lower submucosa.

With further expansion the diverticulum may lift the outer layers to form a bulging protruberance of the intestinal wall but probably will bulge inward, lifting the parent mucosa before it, forming an intra-intestinal cyst.

The expanding cyst, however, is more likely to find a weak place in the inner muscular layer, especially at the point where the blood vessel enters to supply the mucosa and, once outside the inner circular layer of muscles, it expands in the intramuscular tissue, lifting up the outer muscular layer and forming a dome. Further expansion may split the muscle until only the serosa remains over the cyst.

The second theory was first proposed by Saunders[6] who, in 1943, described duplications of the foregut occurring in the posterior mediastinum. These are composed of thick walls covered with longitudinal and circular muscles, having myenteric plexuses and lined with intestinal epithelium. They frequently extend in a caudal direction through the diaphragm and often are asso-

*Presented before the Annual Meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 18, 1963.

†Photography by Richard Crawford, Medical Photographer, Myers Clinic, Philippi, W. Va.

Submitted to the Publication Committee, Sept. 15, 1964.

Figure 1

Figure 2

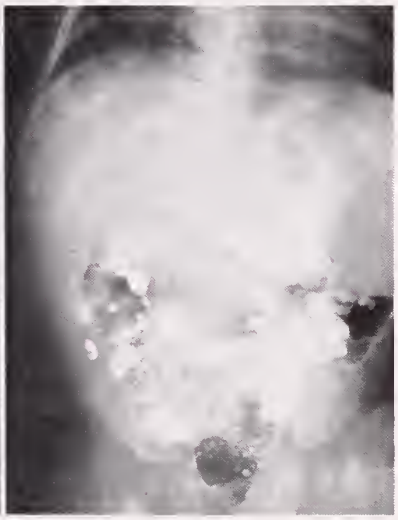

Figure 3

Figure 1. Esophagram. Esophagram appears normal. (Figure 2) Stomach—Note pressure on greater curvature pushing stomach downward. (Figure 3) Stomach at one hour showing defect on greater curvature with stomach displaced forward and transverse colon downward.

ciated with spinal defects. In 1954, he further restated, and described the split notochord syndrome, sometimes called neurenteric canal or dorsal intestinal fistula, with its resultant anomaly often mistaken for a spinal cyst or dermoid cyst, being explained on the basis of partial duplication or separation of the notochord. The notochord theory of origin is based upon the events occuring in the third week of embryonic life, when the notochord begins to appear. Proliferation of cells from the primitive streak of ectoderm produces a narrow rod of cells that project ventrally between the ectoderm and endoderm. This notochordal plate wedges among the endodermal cells, to form part of the wall of the primary endodermal cavity. Normally, the notochordal plate then migrates dorsally and is pinched off from the endoderm by ingrowth of mesodermal cells from each side. If, in the withdrawal of the notochordal elements, ecto-endodermal adhesion results and draws with it some of the adjacent endodermal lining, it becomes impossible for the spinal canal to close ventrally and, in addition, a tract resembling a diverticulum is established with the primitive gut. In these mediastinal cysts or tumors, either or both ends of the intestinal tract so formed may remain open or both may be closed off from their original communications.

In summary, then, the primary causal mechanism is believed to be adhesion between the fetal neuro-ectoderm and endoderm with resulting incomplete separation of the alimentary and neural tracts.

Case Report

P. C. P., a 5-month-old white male child, was admitted to Broaddus Hospital, Philippi, West Virginia, on November 8, 1961, with a history of having been well until 3 A.M. of that date, when he vomited approximately a cupful of bright red blood which was followed within a few minutes by a second episode of coffee ground emesis. The child had had a cold, with considerable coughing for the past two days.

Past history was essentially negative except for episodes of nausea, vomiting and associated diarrhea at the age of six weeks, requiring a change of formula to correct the situation.

Family history was entirely negative; the child was the eighth sibling.

Physical examination revealed a listless, irritable, markedly pallid white male infant. Blood Pressure: Systolic 112/50. Diastolic 92/60. Temperature (rectal): 99.2. Weight 17 pounds, 8 ounces. Eyes, ears, nose and throat were negative except for a watery nasal discharge. The heart was normal; lungs were clear to percussion, with a few roughened breath sounds at both bases. The abdomen was somewhat tympanitic, with the liver edge palpable two fingerbreadths below the right costal margin. There was a firm,

Figure 4. Barium enema with colon displaced downward.

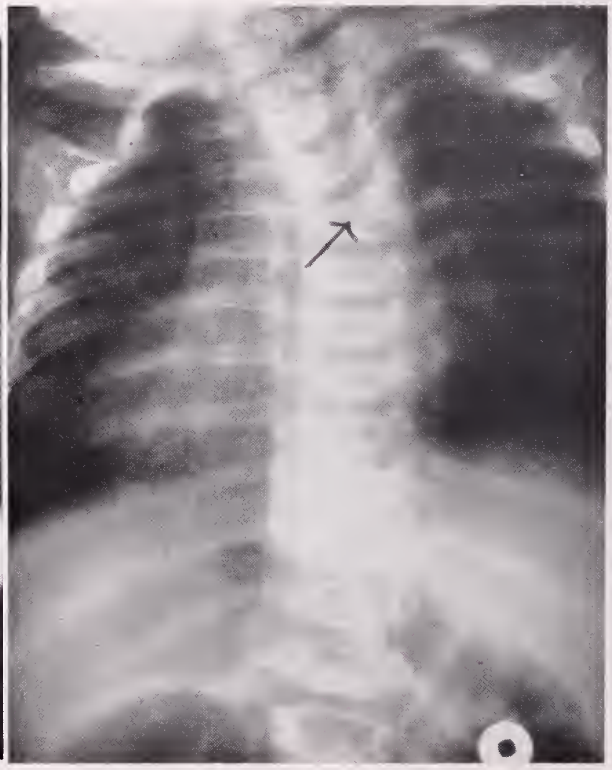

Figure 5. X-ray showing hemivertebrae.

rounded mass roughly 5 x 4 x 5 cm. extending approximately three fingerbreadths below the left costal margin, without a palpable notch. There were slight resistance and tenderness over the mass. The genitalia and rectum were negative, and the stool was of a greenish color without gross evidence of blood. By the second day the mass in the left upper quadrant had disappeared.

Laboratory work revealed a white blood count of 7,400 and 21 per cent granulocytes and 36 per cent band cells; red blood count was 3,000,000 with hemoglobin of 7 Gm. or 47 per cent. The stool gave 3+ Guiac test for blood. Urinalysis was entirely negative. Prothombin time was 50 per cent. Bleeding time was 6½ minutes (normal 1-3 minutes-Duke), and coagulation time was 4 minutes (normal 1-4-Cap. Tube). Blood urea nitrogen wass 11 mg. per cent. Smear for spherocytosis was negative. X-rays of the kidneys were essentially negative except for slight pressure in the central part of the left renal pelvis. Chest x-ray revealed only central nondescript thickening. Upper G. I. series and barium enema were not entirely satisfactory. Because of the upper respiratory infection and unsatisfactory G. I. study, the child was allowed to go home and return in one week for a complete G. I. series.

He was readmitted on November 16, with the return of symptoms of nausea, vomiting and increasing irritability.

On examination, there was a large (approximately 4 x 6 x 5 cm.), round, abdominal mass in the left upper quadrant. The upper G. I. series was repeated, revealing an unexplained mass in the left upper quadrant (Figures 1, 2, 3) which was displacing the stomach forward and downward. The colon also was displaced downward (Figure 4). A provisional diagnosis of duplication of the stomach was made because of (1) gastrointestinal hemorrhage, (2) associated hemi-vertebrae (Figure 5), (3) pressure on stomach and (4) left upper quadrant mass.

Figure 6. Operative photograph showing duplication along greater curvature.

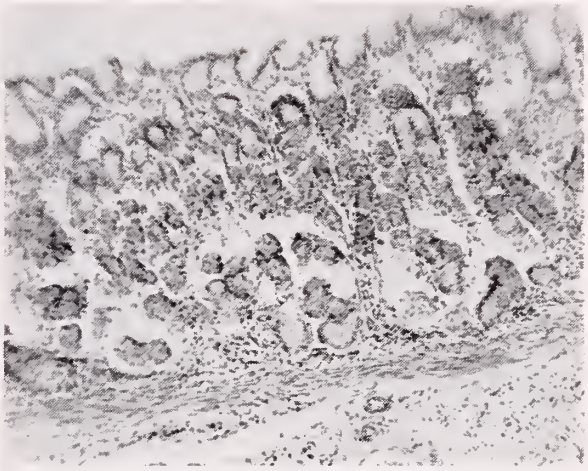

Figure 7. Photomicrograph revealing gastric mucosa in the resected specimen.

The blood count showed 3,300,000 red cells, with hemoglobin 7 Gm. or 47 per cent. The child was transfused and hydrated with appropriate fluids and by November 18 the red cell count was 4,200,000, with 80 per cent hemoglobin.

On November 20 operation was carried out under general anesthesia. The abdomen was opened through a left upper paramedian incision. Exploration was negative except for a firm, cystic mass measuring 6 x 4.5 x 3 cm., occupying the upper and midportions of the greater curvature of the stomach. The gastrocolic omentum was opened and the mass was found to be adherent to the transverse mesocolon. This was freed by sharp and blunt dissection. The entire greater curvature of the stomach was then mobilized. The right gastro-epiploic artery was then divided and ligated and the entire greater curvature of the stomach was skeletanized (Figure 6). A Payr clamp was then placed along the border of the cystic mass including a small portion of normal stomach and the mass excised. The fundal portion of the stomach and esophagus was then examined and an apparent duplication of the esophagus was found. The septum between the main esophagus and the duplication was incised longitudinally and closed transversely so that adequate drainage into the stomach was accomplished. The stomach wall was then closed with an inner layer of continuous suture of No. 000 chromic catgut using a Connel type of suture. A

Figure 8. X-ray of esophagus reveals normal function.

second layer of interrupted Lembert sutures using No. 0000 black silk was used for reinforcement.

Postoperatively, the child was maintained on suction and intravenous fluids for a period of three days, when he was started on oral feedings. These were well tolerated and he rapidly returned to a normal diet.

Pathologic examination revealed a specimen consisting of a hollow organ measuring 6 x 4½ x 3 cm. In one place along the edge there was an opening which showed some mucous membrane around it. The opening was measured 1.5 cm. in diameter. Irregular rugae of mucous membrane lined the inner surface of this hollow structure. There was a definite submucosal and muscular layer. The gross pattern of the mucosa with rugea suggested gastric rather than intestinal location.

Microscopic section revealed typical gastric mucosa and gastric musculature with a tendency to show enteric features of the superficial glands. Diagnosis: Duplication of the stomach (Figure 7).

Discussion

The following points must be remembered when dealing with duplications of the gastrointestinal tract:[7]

1. There may be a slight furrow between the duplication and the alimentary tube but attempts to dissect this free will be met with frustration since they are intimately attached to each other, with fusion of the muscular coats into a common wall.
2. All duplications have well developed muscular coats of smooth muscles consisting of from one to three layers.
3. The epithelium of the duplication always resembles that of some part of the alimentary canal.
4. Duplications vary in size and shape, the most common type being a spherical or ovoid mass.

In this case of duplication of the stomach with associated duplication of the esophagus, x-rays of the esophagus taken on December 20, 1961 (Figure 8), however, failed to show any abnormality or evidence of opening of this duplication into the esophagus. The child has continued to do well. On September 13, 1963, his weight was 32 pounds, his height 36½ inches. There has been no recurrence of symptoms.

Summary

A case of duplication of the stomach and esophagus is reported. The etiology is best explained by split notochord theory.

In most cases, duplication of the stomach makes itself known by a tense abdomen, vomiting, and a palpable mass. Occasional melena and hematemesis occur when there is a communication between the cyst and the stomach, as in the reported case.

Operation is the treatment of choice.

References

1. Green, R. E.: Duplication of the Stomach, Am. J. Surg. 96:721, 1958.
2. Nissan, I.: Duplication of the Stomach, Am. J. Surg. 100:59, 1960.
3. Shelton, Ben & Turner (Cleveland): Duplication of the Stomach. Report of a Case. Am. Surgeon 28:715, 1962.
4. Lewis, F. T. & Thyng, F. W.: Regular Occurrence of Intestinal Diverticula in Embryos of Pig, Rabbit and Man, Am. J. Anat. 7:505, 1907.
5. Bremer, J. L.:Diverticula and Duplication of Intestinal Tract, Arch. Path. 38:132, 1944.
6. Saunders, R. L.: Combined Anterior and Posterior Spina Bifida in Living Neonatal Human Female, Anat. Rev. 87, 1943.
7. Gross, R. E.: Surgery of Infancy and Childhood, Philadelphia, W. B. Saunders Co., pp. 221-245.

Special Article

Rural Development—Problems and Promise*

Dr. Paul A. Miller

American rural life is a study in the paradox and ambivalence contained in the very issues confronting the American public in 1965. These issues include those of unity opposed to multiplicity, of virtues of independence opposed to interdependence, of nationalism and parochialism opposed to internationalism and community. Similarly, in the American farm model we find values sought by urban people; in the city we find opportunities sought by rural people. From the platforms of the 1964 Presidential candidates we heard a mixture of visions of the best of two possible worlds: a land where people are at once rural and urban, nationalistic and internationalistic, independent and interdependent, fractional and consolidated.

In 1965 we are the most affluent nation in history, but we are troubled because that affluence has not touched the lives of 30 million Americans, and a billion non-Americans. We have the most powerful military establishment of any nation in history, and our power both comforts and frightens us. We are proud and desirous of a strong national government, but we fear the shift of power from the states to the Federal government. We want an independent and objective Supreme Court, yet we revile those decisions we may dislike. As a body we call for government by law of the governed, yet far too many among us ignore the law if we disagree with it. At the local level, we want government of all kinds to help us and to leave us alone, to be at the same time progressive and reactionary, liberal and conservative.

These paradoxes we share as a people, rural and urban, West Virginian and Californian; indeed, American and African, Pennsylvanian and Brazilian. This is a century of violent international paradoxes. It has seen the most brutal hate and destruction, yet the most compassion and progress in the history of the world. Millions of people have been killed by technological war, yet millions have lived because of technological medicine. It is the century when man decides whether his inventions will dominate or serve him, destroy or preserve him. It is the pivotal century of civilization, whether it advances or retreats, frees or conquers. It is the century, as S. N. Behrman put it, in which man finally must decide whether Napoleon or St. Francis is his hero. American civilization is the focal point of this struggle. As we hesitate on the threshold between the past and the future, the world gasps to see which way we shall turn.

The Author

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The Case of Rural America

In times such as these, of the mammoth and superlative and the gigantic and unfathomable, it is little wonder that the case of rural America may be low in the national scale of values. Rural people are a diminishing minority. Less than ten per cent of the farms feed the nation. The average American family spends less than twenty per cent of its income for food. The urban case dominates the headlines of newspapers. Race, hooliganism, and murder on subways squeeze out from the public's attention the slow processes of rural America. The present generation in its thirties has been removed from the farm for three generations. When, finally, the public at large is confronted with the history of rural life during the last half-century, it has professed amazement. The events of this history, told in the story of a rural society becoming an urban industrial society, have been presented forcefully to us in 1964. It is an American paradox.

At the heart of the paradox is the assumption of the idyllic farm. The farm always has been the home of traditional American values of hard work, free enterprise, morality and religion, the strong belief in the family as an enclosed, perpetuating circle of comfort and conviction.

*Presented in slightly different form before the 17th Annual Rural Health Conference, sponsored by the West Virginia State Medical Association at Jackson's Mill on October 1, 1964.

Democracy itself has been assumed to have come from a love of the soil, a world of primacy of the farmer, calloused palms and independence, land and equal opportunity. From this assumption there came a mystical belief that the simplicity and directness of rural life were basic to the American way. The paradox is that on the farm, where these virtues were believed strongest, we discover a very meager return for so great an investment of faith. Rurality seemed to associate with relatively weak inclinations toward change, personal adventure, vocational aspiration, and adjustment to new community situations. Living on the farm became unprofitable; technological change, economies of scale, bigness and science, made the farmer, as we once knew him, less and less apparent.

This paradox, which is the result of the present blending of urban and rural life, may be put another way. In spite of a century and more of large-scale public and private investment in agriculture and rural life, in spite of several armies of technical personnel devoted to a host of special rural interests, in spite of one of the most highly organized parts of American life, we continue to experience persistently chronic symptoms of disorder in rural life—relatively lower incomes per family, institutional services (including health care) commonly below the standard which our society has come to expect, and a frequent pattern of retreat from the rapid change of the times.

The Appalachian Region

The case is poignant in the Appalachian Region. Two-thirds of the residents of the Southern Appalachians are classified as "rural." More than half of them have incomes below $3,000—the figure used nationally as the borderline of poverty. Schools are understaffed, teachers underpaid, less than half of the students complete high school, less than one-fifth enter college. The low level of educational achievement is largely responsible for the low level of the economy. This is so because knowledge is central to the modern economic enterprise. The same causes are applicable to the dissolution of the small, inefficient farm.

Other community institutions and services have long suffered or been non-existent in the rural case. The West Virginia State Department of Health has estimated a minimum need in West Virginia for 11,522 additional hospital beds, and 121 new diagnostic, treatment, and rehabilitation centers. Adding these immediately would bring West Virginia up to the national standards of 1963! West Virginia needs twice its present number of physicians to bring it to the national average of one physician for 700 people. Ten counties in West Virginia have more than 3,000 people per physician; four counties more than 5,000; only two, Monongalia and Ohio, rank better than the national ratio. Twenty-five counties have infant mortality rates higher than the national average.

Six of the counties considered Southern Appalachian in West Virginia have more than 6,000 people for every dentist; one county has more than 11,000 per dentist. To bring the Appalachian region even with the standard of the nation would require 1,700 additional dentists. We are told by public health authorities that there should be at least one public health nurse for each 5,000 people. Only one of the Southern Appalachian counties of West Virginia meets this standard. Four counties have only one nurse for more than 20,000 people. By all standards, the level of health care in the Southern Appalachian Region, including West Virginia, is below that of the nation.

A National Problem

But the region is not alone among the predominantly rural areas of the United States suffering from a lack of vigor in community services. It is a national problem. How has this happened? There are at least three basic causes.

First, the rural case demonstrates how an investment in technology greater than the investment in human resources and institutions can have disastrous consequences for the quality of human life. Human, natural, and capital resources must develop together and in balance. Otherwise, man is unprepared by education to change his way of living in order to meet the change in the world about him.

Second, the rural community has resisted experimentation and planned change in its institutions. Rural and small-scaled institutions tend to go together. Small jurisdictions for health care, schools, and government, although once sufficient, are no longer adequate to provide the services people expect.

Third, the help that rural America has received from society has emphasized material goods to the virtual exclusion of human development. While the farmer and government were engrossed in price supports, the rural schoolhouse was rotting away, the teachers were leaving, and the children were becoming unemployable dropouts.

Many rural areas are centers of a vicious circle. The foregoing points together with out-migration of young people, the shrinking of the tax base,

the rapid increase of the more dependent ages—the very young and the very old—draw a circle that is very difficult to cut through. I am prepared to argue that the only way to do so is to obtain the most competent and innovative personnel at every point in the society where people learn to live and to work up to the level of American life. In the schools, in the community agencies serving families, in the organizations devoted to raising the quality of community life, competent leaders will find ways to plant ideas, methods, experience, and call out the opportunities of the greater society. The colleges and universities of West Virginia, together with State and Federal agencies and private organizations, are keys to this task, each in its own area of special competence.

WVU Medical Center

In the matter of health, for example, the Medical Center of the University which I represent has a responsibility to the entire State. The Medical Center has now reached the stage of its development of searching for ways to distinguish itself as an active force within the State. The destiny of the Medical Center can never be justified solely by the number of graduates in the health professions who go out into the State and elsewhere to practice their professions, but by the impact that the total range of programs — in education, research, and public service—will have on the entire level of medical and health care, on the vigor of our community health institutions and agencies, and on the continuous opportunities for enrichment and growth which the Center may provide to the medical and health professions. As you may know, two new divisions have been established in the Medical Center with these purposes in view—the Division of Preventive Medicine and Public Health, and the Division of Academic Communications.

Such a role for the Medical Center leads quite naturally to the matter of partnership among the various agencies and institutions with an interest in health improvements. It is clear, in view of West Virginia's needs, that we must call out more strongly than we have about the importance of health services to the social and economic development of the State. It is fair to say that the economic growth of West Virginia has been seriously retarded by its health problems. Without a vigorous, healthy people responsive to self-improvement, programs of development are destined for less than adequate results. This is absolutely fundamental to the development process, and underscores again the need for investment in human resources as great as the investment in hardware and the trappings of industry. Development is only for those who can take advantage of it, and people must learn to do so.

As West Virginia keeps working to find the strategy of balanced development, the Medical Center must give leadership to pointing out and working upon such issues as our poor relative position in unmet medical needs, the fact that we do not have enough physicians, dentists and nurses, and that many smaller communities are unable to find even one physician to serve them. Nor can this undertaking be viable should it overlook the features of West Virginia's population. Although the population of West Virginia consists of age groups approximately equivalent to the national averages, the population of most rural and underdeveloped counties in West Virginia consists of a predominant proportion of the very young and the very old. This fact, together with their relative isolation from the centers of health care, calls for increased attention to the special needs of these rural people. We need more experimentation with methods of reaching them, and we need to employ far more than we have the concept of mobile services. The people have done rather well in seeking out services for themselves, but we must ask ourselves how effective we have been in going out to the people.

Regional Organization of Services

A second concept needing renewed attention is that of a regional organization of services. It has been clear for years that the county system of services is obsolete. New arrangements need to be established whereby clusters of counties around urban centers may be reached from a central agency. To replicate at the county level the vast facilities needed for adequate health care would be prohibitively expensive; instead, we need to develop regional centers of deep resources with highly mobile facilities. Again, consolidation of public health facilities, as with other community services, is a feasible approach for a State unable to afford any longer the spreading of its limited resources over so great an area.

Comprehensive Approach to Development

A third point has to do with a need for a comprehensive approach to development, including the strategies for better health care. This approach would recognize that emphasis on health services alone will not accomplish the task of sufficiently improving the health of West Virginians. In addition to this, similar inroads must be made in the improvement of living standards—housing, counseling, family aspiration, and community life. The community that allows its streams to be open sewers can scarcely expect the citizenry

to be annoyed with outdoor toilets. This may be a matter of skimpy economic resources; and yet a people sufficiently indignant over low standards can always find a way to improve them—if they are determined to do so.

My point is to suggest an even broader approach than would be found in a typical, organized attack on public health problems. It would be a program involving all of the environmental sciences—the health sciences, engineering, natural resources, and the social sciences, including sociology, psychology, and other disciplines interested in social planning and its philosophy. It would be a truly inter-disciplinary effort with a strong academic foundation and an active field organization. Future planning at West Virginia University will consider such possibilities for development and emphasis as a whole new service sector of University activity. The recent decision of the U. S. Department of Health, Education, and Welfare to locate in Morgantown the Appalachian Division of the National Environmental Health Center, is an auspicious development strongly influencing University planning.

Such an innovation of environmental science strikes at the roots of a national problem: the absence of an over-all attempt to extend the abundance of material comfort to a greater number of Americans and to develop human resources to meet human needs. To put it another way, we have constructed the vast technological machinery of a civilization at the expense of the civilization itself. If life is hollow, perhaps it is because we have exhausted ourselves building a facade. Although we have put science and technology to so many successful uses, we have not been able to achieve a comparable effect in the quality of human life—as evidenced in the pollution of the natural environment, in community disorganization and delinquency, in personal loneliness amid mass congestion, and in such areas of the nation as Appalachia needing massive development. Nor is there quality in our widespread indifference to fellow citizens who have not enjoyed the abundance of middle-class life. As one writer has put it: "In a nation with a technology that could provide every citizen with a decent life, it is an outrage and a scandal that there should be such social misery." He is talking about "the other America," the invisible poor. But though we may do so, we must at the same time be sensitive enough, cynical enough, to know that mere economic development is not development at all—without considerable surveillance of the quality of human development. The standard of community services and health care will not matter much without a concern for the totality of comprehensive development.

Cooperative Activity

West Virginia must find a way to obtain the most competent educational personnel; to do so will probably require help from all levels of government. In addition, there is a need for emphasis on more and better counseling services, for both adults and youth—to call out to each person what it is possible for him to become. Equally important is the need in rural communities for more programs beyond the high school of terminal nature. With the growth of the community college movement we have learned that more people are enticed into education beyond high school when the opportunities are afforded near their homes. However, this is not the same thing, nor a substitute for, better use of our programs of vocational education—in technical skills, in the crafts, and in knowledge of the world of work.

Central to the entire undertaking is a strong university working hand in hand with the school system, State and Federal government, and private organizations such as the West Virginia State Medical Association. Such Federal programs as the Economic Opportunity Act of 1964 and the Appalachian Development Act offer new possibilities for cooperative activity. More cooperative programs would be a credit to the initiative of West Virginians who wish to help themselves by organizing the resources we already have to make development possible. I hope we may remember that our present resources are by no means meager, but they sometimes seem to be because we frequently fail to identify them or to bring them together.

West Virginia has entered its second century. Before much more of it goes by, let us work together to find a way to arrange our resources, to develop them, and to share them more equitably with those among us, rural and urban, who have been pushed off the main road of American life.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 26-28, 1965

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

OUR LEGISLATIVE TRAVAILS

As another month of our epic struggle rolls on, and as medicine stands poised on the brink of this socialistic precipice, there is beginning to be noted a unity of purpose and ideas among the physicians in our state and across this country. The campaign to inform the American people, our patients, of the issues involved is evident in Washington by the rewriting of the medical care for the aged bill by the House Ways and Means Committee to include much that medicine advocates. The fact that the Committee will not hold open hearings at this time is most disturbing and is not in keeping with democratic traditions and processes. At this writing, the bill has not been released by the Committee and we must wait to see if it will be acceptable to medicine in its final form. We continue to fight for a bill which will provide the best medical care for the aged as in the Herlong-Curtis bill (HR 3727).

On another front, in the legislative halls of our State Capitol, we again may say that when reasonable and honorable legislators are given the true facts, they will act accordingly. Our sincere gratitude to the legislators, our Governor Hulett C. Smith and his official family for being guided by the principle of doing what is best for the health of all the people of our State.

Other problems remain and the solutions must be found by the concerted effort of all physicians. We are beset with the problem of increased hospital costs, the lack of medical personnel, which is increasing the work of the already overburdened physicians in active practice, and the lack of interns and residents in our community hospitals which has become an ever more pressing problem and of which we are more acutely aware. Our efforts to give the best in medical care and attention is being further hampered by legislative consideration by men who are not physicians and whose only goal is a socialistic government—when will they learn that bridges cannot be built without aid, advice and consultation with engineers?

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

AMNIOTIC FLUID EMBOLISM

Elsewhere in this issue may be found an article dealing with Amniotic Fluid Embolism. The cases involved were from the files of the Maternal Welfare Committee of the West Virginia State Medical Association, and an additional fatal case from the author's own records. There has been an increase in the number of cases reported in the medical literature in recent years, and probably many more unreported.

The condition is classified under accidents during labor, and fortunately is still relatively rare. It is caused by the passage of amniotic fluid containing many fine particles of meconicum, vernix caseosa and lanugo hair into the maternal circulation causing a chain of reactions which, with few exceptions, terminates in sudden death of the patient.

Certain categories of patients seem to have an increased susceptibility to amniotic fluid embolism. It has been observed that the incidence was highest in multiparous white women who had reached term. It was also more likely to occur in patients who received oxytoxics during labor especially following rupture of membranes, and in those patients who experienced a tumultous labor or had large babies. Because of this, and other additional important reasons, the importance of constant supervision and control of the use of oxytoxics during labor must be stressed.

The wealth of clinical and pathological material to be found in the files of the Maternal Welfare Committee is quite obvious. A much wider use of this material source is to be encouraged in the writing of case reports and scientific papers for the continuing education of the profession. The excellence of the present case reports and discussion in this issue of *The Journal* is to be commended.

FEDERAL GRANTS FOR UNDERGRADUATE AND RESEARCH TRAINING

In 1948 federal grants were first made to medical schools for the support of undergraduate and research training. In that year $1,607,274 was made available for undergraduate training and $48,143 for research training. The former were originally known as teaching grants and had to do with instruction in cardiovascular diseases, oncology and psychiatry. For the most part the grants for research training had to do with stipends for predoctoral and postdoctoral fellows who were involved in training for research.

As would be anticipated, more money was allotted each year for these grants. In 1958, that is, ten years after the grants were first made, $6,256,681 was allotted to undergraduate training and $12,894,979 for research training. It will be noted that the funds for research training grants increased much more than those for the undergraduate training grants. This was even more pronounced in 1963. In fact, the undergraduate training grants have leveled off at approximately $7,500,000 whereas, the research training grants have risen to over $67,000,000.

The question has been raised whether these huge sums of money will bring about federal control of medical education. Actually, the money is divided pretty much between all the medical schools (about 85) although by no means in even proportion. If we assume that each medical school shares, in part at least, in these funds, the money involved is only a relatively small part of the budget of a medical school.

Some criticism has been offered to the effect that many students, especially the predoctoral fellows, supported by research training grants are not particularly interested in research, but simply enroll in the program because of financial reward. The predoctoral fellows doubtless should be screened carefully and only those selected who give distinct promise of developing into creative workers. Some critics, moreover, suggest that the value of the research contributions made by those who are not spontaneously and wholeheartedly interested in research, are but meager and merely muddy the research literature which already is vast. Be that as it may, it is thought by many that the research training grant program has been of real aid. This is especially true since the demand increases for well trained full-time medical faculty members, and also because a number of new medical schools are presently being developed. A reasonably conservative program would seem to be in order. Those responsible for the recommendation of grants should take every precaution to allocate the funds fairly and wisely.

Certainly the research training grant programs should not place an undue burden on those members of the faculty who are primarily responsible for teaching medical students. While research is a most important function of a medical school, and, indeed, research cannot be separated from good teaching, it should always be borne in mind that a medical school has the great responsibility of preparing students for the practice of medicine.

THE AMA MEETING IN NEW YORK CITY

The year 1965 is a crucial year for American Medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America. An outstanding highlight in medicine in 1965 will be the 114th Annual Convention of the American Medical Association in New York City, June 20-24. It is our conservative estimate that more than 10 per cent of all American physicians, and perhaps as many as 15 per cent of those in private practice, will register for the New York convention.

Nowhere else in the entire world do physicians gather in such numbers to continue their medical education in an intensive short course that, literally, has something for everyone. Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians do not attend the AMA annual convention just to take a trip to New York, although that is an interesting sidelight. They attend because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.—*Guest Editorial by Donovan F. Ward, M. D., President, American Medical Association.*

In Praise of Drug Advertising

All studies show clearly that pharmaceutical advertising is effective and that it is useful. Information is sought by physicians, from the detail man, from journal advertising, and from direct mail advertising, usually in that order. Occasional nuisance though it may seem to be, it is clear that pharmaceutical advertising is much too important to be ignored as a factor in progress.—H. L. Hartley, M. D., in Northwest Medicine.

GENERAL NEWS

Dr. R. Gordon Douglas To Speak At 98th Annual Meeting

A prominent authority in the field of obstetrics and gynecology will be among the guest speakers at the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, announced that Dr. R. Gordon Douglas of New York City had accepted an invitation to appear as guest speaker at the first general scientific session on Thursday morning, August 26.

R. Gordon Douglas, M. D.

Doctor Douglas is Professor of Obstetrics and Gynecology at Cornell University Medical College, and also serves as Obstetrician and Gynecologist - in - Chief at The New York Hospital.

A native of Winnipeg, Canada, Doctor Douglas attended the University of Alberta and received his M. D. degree in 1924 from McGill University Faculty of Medicine in Montreal.

He had postgraduate training at the Montreal General Hospital and continued his training in obstetrics and gynecology at the Johns Hopkins University Hospital in Baltimore. He had a year's study in bacteriology at the University of Rochester School of Medicine and a second year at several clinics in Europe.

Doctor Douglas joined the staff of the Cornell University Medical College and The New York Hospital in 1931, and since 1949 has served in his present positions. He also serves as Honorary Consulting Surgeon to the Royal Women's Hospital in Melbourne, Australia.

He is a past president of the New York Obstetrical Society, American Association of Obstetricians and Gynecologists, and the American College of Obstetricians and Gynecologists. He also is a past president of the Section on Obstetrics and Gynecology of the American Medical Association, and is currently serving as first vice president of the American Board of Obstetrics and Gynecology.

He has had numerous papers published in scientific journals on subjects in the field of obstetrics and gynecology.

Scientific Program Nearly Completed

Doctor Stevens announced that arrangements have nearly been completed for the general scientific program which will be presented during the three-day meeting. The other members of the Program Committee are Drs. Richard W. Corbitt, Parkersburg; Jack Leckie, Huntington; Kenneth G. MacDonald, Charleston; Maynard P. Pride and Clark K. Sleeth, Morgantown.

It was announced previously that Dr. Walter H. Judd had accepted an invitation to appear as a guest speaker prior to the opening of the first scientific session on Thursday morning, August 26.

Doctor Stevens said that members of the Auxiliary and other guests attending the meeting at The Greenbrier are cordially invited to listen to the address by Doctor Judd. A former medical missionary and congressman from Minnesota, Doctor Judd is considered one of the country's leading statesmen. He served in Congress for 20 years and was a member of the key Committee on Foreign Affairs for 16 years.

Important Changes in Program For Annual Meeting

The Program Committee has announced two important changes in the program for the 98th Annual Meeting of the State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 26-28.

The first session of the House of Delegates will be held on Wednesday afternoon, August 25, the day preceding the formal opening of the convention. Heretofore, the first session had been held on Wednesday evening.

The pre-convention meeting of the Council will be held on Wednesday morning and this will mark the first time in many years that a meeting of the Council has been scheduled in the morning during the meeting at The Greenbrier.

Members of the Council have been urged to notify The Greenbrier immediately if they plan to register on Tuesday evening. Delegates also are asked to arrange their schedules accordingly in order to be in attendance at the first session of the House of Delegates on Wednesday afternoon.

Dr. Carl B. Hall To Present Paper At Annual AAGP Meeting

Dr. Carl B. Hall of Charleston will be among the participants in a Symposium on Obstetrics and Gynecology which will be presented during the 17th Annal Scientific Assembly of the American Academy of General Practice in San Francisco, April 12-16.

Doctor Hall will discuss "Induction of Labor." Other speakers will be Drs. Waldo L. Fielding of Boston and Walter J. Reich of Chicago.

Carl B. Hall, M. D.

Doctor Hall and Dr. Seigle W. Parks of Charleston will represent the West Virginia Chapter, AAGP. Alternate delegates are Drs. Halvard Wanger of Shepherdstown and J. Keith Pickens of Clarksburg.

The theme of the 1965 Assembly is "The Community in Medical Perspective." It is a continuation of "Perspectives in Medicine," a comprehensive medical program established for doctors at the 1963 convention in Chicago.

Thirty-two speakers and 100 scientific exhibits will comprise the scientific program which will focus special attention on community health problems and the family physician's responsibility toward them.

This year the Academy will offer an extra day of medical lectures and 24 clinical refresher courses. The refresher courses will consist of two half-day sessions at eight San Francisco hospitals and at the Civic Auditorium.

One of the features of the meeting will be a panel discussion on "Abortion and Control of Conception." The speakers will be Dr. Alan F. Guttmacher of New York City and Dr. Edris Rice-Wray of Mexico City.

Other topics during the five-day session will include emergency treatment of chest trauma, biliary-tract surgery, skin disease management, genetics and disease, and recent developments in allergies. A closed-circuit TV broadcast will demonstrate office plastic surgery techniques on a live patient at a local hospital.

Dr. Amos N. Johnson of Garland, North Carolina, will be installed as President of the Academy during the meeting, succeeding Dr. Julius Michaelson of Foley, Alabama.

Two Physicians Certified

Two Huntington physicians, Drs. Sidney Auerbach and Gerald E. Vanston, were recently certified as Diplomates of the American Board of Pathology.

New Association Members

Dr. Elwood H. Heilman, 1208 Kanawha Boulevard, E., Charleston (Kanawha). Doctor Heilman was born in Ida Grove, Iowa, and received his M. D. degree in 1941 from the University of Oklahoma School of Medicine. He interned at the Medical College of Virginia, 1941-42, and served as a Major in the Medical Corps of the United States Army, 1942-46. He practiced in Iowa until 1961, at which time he returned to the Medical College of Virginia to serve a residency. His specialty is orthopedic surgery.

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Dr. Joseph C. Ray, Stevens Clinic Hospital, Welch (McDowell). Doctor Ray, a native of McLean County, Kentucky, was graduated from the University of Kentucky and received his M. D. degree in 1929 from the University of Louisville School of Medicine. He interned at St. Anthony's Hospital in Louisville, 1929-30, and served a residency at the New York Eye and Ear Infirmary, 1943-45. He was previously located in Louisville and his specialty is otolaryngology.

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Dr. Harold D. Warren, 204 Queen Street, Beckley (Raleigh). Doctor Warren, a native of Sharon, Massachusetts, was graduated from Brown University and received his M. D. degree in 1937 from McGill University School of Medicine in Montreal. He interned at Baltimore City Hospital, 1937-38, and served residencies at the Peter Bent Brigham Hospital in Boston, Kings County Hospital in Brooklyn and Willard Parker Hospital in New York City. He served as a Lt. Colonel in the Medical Corps of the United States Army, 1941-46, and he was previously located in Bangor, Maine. His specialty is internal medicine.

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Dr. John T. McMurray, 885 National Road, Wheeling (Ohio). Doctor McMurray, a native of Parkersburg, was graduated from Duquesne University and received his M. D. degree in 1963 from the West Virginia University School of Medicine. He interned at Wheeling Hospital, 1963-64. He served with the United States Air Force, 1952-56, and he is engaged in general practice.

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Dr. Ebb K. Whitley, Jr., Iaeger (McDowell). Doctor Whitley, a native of Glen Alum, was graduated from Emory and Henry College and received his M. D. degree in 1963 from the Medical College of Virginia. He interned at Roanoke Memorial Hospital in Roanoke, Virginia, 1963-64, and he served for four years with the United States Air Force. He is engaged in general practice.

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Dr. Ernesto J. Josef, Jackson General Hospital, Ripley (Kanawha). Doctor Josef, a native of the Philippines, received his M. D. degree in 1956 from the University of Santo Tomas and served his internship at Mercy Hospital in Hamilton, Ohio. He served a residency at St. Francis Hospital in Charleston, 1959-63, and he was licensed to practice in West Virginia in 1964. He is engaged in general practice.

Spring Board Meeting of Auxiliary In Morgantown, April 26-27

The Spring Board meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held at Mont Chateau Lodge near Morgantown, April 26-27.

Mrs. George A. Curry of Morgantown, the president, announced that a workshop for county officers and committee chairmen will be held in conjunction with the meeting.

The meeting of the Board of Directors will be held on Monday afternoon, April 26, beginning at two o'clock. Later that afternoon there will be a tea and entertainment skit by the Woman's Auxiliary to the Student American Medical Association of the WVU School of Medicine.

A dutch treat dinner will be held that evening at Lakeview Country Club, which will be preceded by a social hour.

Mrs. Wilson P. Smith, the president-elect, will preside at the workshop which will be held on Tuesday morning. Members attending the meeting have been invited to tour the West Virginia University Medical Center on Tuesday afternoon.

Dr. William B. Bean To Speak At WVU Medical Center

Dr. William B. Bean of Iowa City, Iowa, has accepted an invitation to speak at the West Virginia University Medical Center in Morgantown on April 29.

Doctor Bean, who is Head of the Department of Internal Medicine at the University of Iowa College of Medicine, will deliver the annual lecture for Alpha Omega Alpha, honor medical society. The program will be held in the main auditorium at 4:00 P.M. The subject of his paper will be "Physicians and Books: The Legacy of the Gold-Headed Cane and Its Tradition."

Doctor Bean received his M. D. degree in 1935 from the University of Virginia School of Medicine and is noted as a writer and lecturer. He is currently serving as Chief Editor of the *Archives of Internal Medicine.*

Physicians throughout the State have been extended a cordial invitation to attend the lecture.

PG Course in Endocrinology

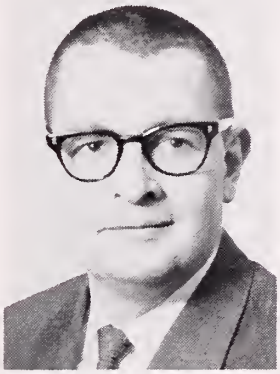
The Cleveland Clinic Educational Foundation will sponsor a postgraduate course in "Recent Advances in the Diagnosis and Treatment of Thyroid Disease" in Cleveland, April 14-15.

The course will be presented by staff members of The Cleveland Clinic Foundation assisted by several guest speakers. The registration fee will be $30.

Additional information may be obtained by writing to The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Edward D. Hagan Named Member Of Headquarters Staff

Edward D. Hagan has been named assistant to the executive secretary of the West Virginia State Medical Association. The appointment was announced by Dr. Charles L. Goodhand of Parkersburg, Chairman of the Council.



Edward D. Hagan

Mr. Hagan, who has been a member of the staff of the Associated Press in Charleston for the past five years, assumed his new duties on March 15.

A native of Morgantown, Mr. Hagan attended Kentucky Military Institute and was graduated from Marshall University in 1958 with a B. S. degree cum laude in advertising and journalism. While at Marshall he was active in a number of organizations and also worked full time for the Associated Press. He was elected to membership in Sigma Delta Chi, professional journalism society.

Following graduation from Marshall, he served for two years with the U. S. Army. He was released from active military duty in 1960 and rejoined the AP in Charleston. His duties with the AP included coverage of state government, radio news writing, election coverage and general reporting and editing.

He married the former Phyllis Jean Wells, who is employed by the State Board of Education.

Miss Gertrude Humphreys Speaks At Rural Health Conference

Miss Gertrude Humphreys of Morgantown participated in a symposium at the 18th National Conference on Rural Health which was held at the Americana Hotel in Miami Beach, Florida, March 26-27.

Miss Humphreys, State Leader, Home Demonstration Work, took part in a discussion on "Developing Community Health Resources."

Dr. Edward R. Annis, former president of the American Medical Association, spoke on "Medical Freedom: An Art and a Science" at a conference banquet.

Dr. W. Ryan Washburn of Boiling Springs, North Carolina, Chairman of the AMA Council on Rural Health, presided at the two-day meeting.

Coccidioidomycosis Symposium in Phoenix

The Second National Symposium on Coccidioidomycosis will be held at the Del E. Webb Town House in Phoenix, Arizona, Dec. 8-10.

Additional information may be obtained by contacting the Arizona Tuberculosis and Health Association, Inc., 733 West McDowell Road, Phoenix, Arizona 85007.

13th Annual GP Scientific Assembly In Wheeling, April 30-May 2

The 13th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice will be held at Oglebay Park in Wheeling, April 30-May 2. The scientific sessions will be held at Wilson Lodge.

Dr. Jack Leckie of Huntington, general chairman of the convention, announced that 18 physicians and surgeons have accepted invitations to appear as guest speakers. More than 200 physicians are expected to attend the two-day meeting.

Russell V. Lucas, Jr., M. D.

Alton Ochsner, M. D.

Dr. Myer Bogarad of Weirton is chairman of the program committee and local arrangements are under the direction of Dr. H. L. Hegner of Wellsburg.

Heart Association Program

Dr. Peter A. Haley of Charleston, the president, will call the meeting to order on Friday afternoon, April 30, and the scientific session that afternoon will be devoted to a program sponsored by the West Virginia Heart Association. The speakers will be members of the faculty at WVU School of Medicine and the moderator will be Dr. Herbert E. Warden of Morgantown, Professor of Surgery and Head of the Division of Thoracic and Cardiovascular Surgery.

The speakers and their subjects are as follows:

1:15—"The Problem of Chest Pain."—Robert J. Marshall, M. D., Professor of Medicine and Head of the Division of Adult Cardiology.

2:00—"Diagnosis and the Treatment of Acute Rheumatic Fever."—Russell V. Lucas, Jr., M. D., Associate Professor of Pediatrics and Head of the Division of Pediatric Cardiology.

3:15—"Syncope."—Alphonse C. Edmundowicz, M. D., Associate Professor of Medicine, Division of Adult Cardiology.

4:00—Panel Discussion.

Saturday Morning, May 1

9:00—"Treatment of Seizures."—Bernard Jacob Alpers, M. D., Professor of Neurology, Jefferson Medical School, Philadelphia.

9:40—"The Modern Management of the Menopause."—M. Edward Davis, M. D., Chairman, Department of Obstetrics and Gynecology, The Chicago Lying-In Hospital, Chicago.

10:50—"Edematous States: Their Similarities and Differences in Therapy."—John H. Moyer, M. D., Professor of Medicine and Chairman of the Department of Medicine, Hahnemann Medical College.

11:30—"Plugged up Babies."—H. William Clatworthy, Jr., M .D., Professor and Chief of the Department of Pediatric Surgery, Children's Hospital, Columbus.

12:00—Panel Discussion.

Saturday Afternoon

2:00—"The Fatty Liver."—Charles M. Caravati, M. D., Professor of Medicine, Medical College of Virginia, Richmond.

2:40—"Management of Urinary Infections in Children."—John D. Young, Jr., M. D., Professor of Urology, University Hospital, Baltimore.

3:50—"Normal and Abnormal Female Reproductive Physiology."—William F. Mulligan, M. D., Director, Fertility and Endocrine Clinic, Free Hospital for Women, Harvard Medical School.

4:30—"Ulcerating Lesions of the Stomach."—Alton Ochsner, M. D., Director, Ochsner Clinic; and Professor of Surgery, Tulane University, New Orleans.

5:10—Panel Discussion.

Sunday Program

9:00—"Real Versus Supposed Disturbances of the Endocrine Glands."—Edward H. Rynearson, M. D.

10:50—"The Management of Grief."—Edward M. Litin, M. D., Department Head, Section of Psychiatry, the Mayo Clinic.

11:30—"Causation—The Lawyer's View and the Doctor's View."—Oliver Schroeder, Jr., Director, The Law-Medicine Center, Western Reserve University, Cleveland.

12:10—"The Constitutional Factors in and the Treatment of Asthma."—Ethan Allan Brown, M. D., Editor, Annals of Allergy.

12:50—Panel Discussion.

Edward H. Rynearson, M. D.

Edward M. Litin, M. D.

Doctor Leckie To Be Installed as President

Dr. Jack Leckie of Huntington, the president elect, will be installed as president during the meeting, succeeding Dr. Peter A. Haley of Charleston.

Other officers are Dr. L. Dale Simmons of Clarksburg, vice president; Dr. Martha J. Coyner of Harrisville, secretary; and Dr. Del Roy Davis of Kingwood, treasurer. Dr. Joseph A. Smith of Dunbar is chairman of the board of directors and Dr. Carl B. Hall of

Charleston, Editor of *Mister Doc*, official publication of the Chapter.

Doctor Rynearson Banquet Speaker

Dr. Edward H. Rynearson, Senior Consultant in Endocrinology and Metabolism at The Mayo Clinic will be the speaker at a banquet which will be held on Saturday evening. His subject will be "It's Hard to Live with a Doctor's Wife."

An interesting entertainment program has been arranged for wives of physicians in attendance at the meeting.

Session on Stroke To Be Feature Of Annual AHA Meeting

A one-day scientific session on stroke will be presented in connection with the American Heart Association's 1965 Scientific Sessions which will be held at the Americana Hotel in Miami Beach, Florida, October 15-17.

The session on stroke will be presented on Saturday, October 16, and neurologists, neuropathologists and neurosurgeons are invited to submit abstracts of papers for the meeting.

Another highlight of the AHA meeting will be the George E. Brown Memorial Lecture. The speaker will be Dr. James F. Toole, Chairman of the Department of Neurology at Bowman Gray School of Medicine of Wake Forest College, who will speak on "Inter-Arterial Shunts in the Cerebral Circulation."

Further information concerning the program may be obtained by contacting the West Virginia Heart Association, 759 Washington Street, W., Charleston, W. Va.

New Laboratory for Cancer Research At WVU Medical Center

The Charleston Foundation Laboratory for Cancer Research will be dedicated at the West Virginia University Medical Center in Morgantown on Saturday, April 24.

The dedication will be held in conjunction with the First Annual Cancer Teaching Day, which is open to representatives of the health professions throughout West Virginia.

A plaque will be placed in the laboratory in memory of the late G. B. Capito, who established the Charleston Foundation for Research Chair at the Medical Center.

Dr. James F. Holland, Director of the Cancer Clinical Research Center and Chief of Medicine at Roswell Park Memorial Institute in Buffalo, will be featured speaker for Cancer Teaching Day. Doctor Holland will be introduced by Dr. Chauncey B. Wright, Chairman of the Cancer Committee of the West Virginia State Medical Association.

Doctor Holland will speak twice. His topic at the morning session will be "Leukemia Treatment—A Crucible and Proving Ground." In the afternoon he will talk on "From Benchside to Bedside."

There will be an afternoon tour of the laboratory, followed by the unveiling of the plaque. Charles L. Capito, nephew of Doctor Capito and executive director of the Foundation, will speak at the dedication.

Doctor Capito practiced medicine in Charleston until his death in 1960. He served as president and medical director of Kanawha Valley Hospital from 1939 until 1959, when he established the Charleston Foundation.

Performing research on mice in the Charleston Foundation Laboratory for Cancer Research at the WVU Medical Center is Dr. Alvin L. Watne (seated), associate professor of surgery. Also at work are, from left, Dr. Henry F. Mengoli, instructor; Marie Kelly, lab technician; Dr. Bedrettin Gorgun, instructor in surgery; Alisia San Julian and William Riffle, lab technicians.

Public Health Association Meeting In Wheeling, May 12-14

The West Virginia Public Health Association will hold its 41st annual meeting at Oglebay Park in Wheeling, May 12-14.

Selden D. Bacon, M. D.

Dr. Selden D. Bacon, director of the Rutgers Center of Alcohol Studies and professor of sociology at Rutgers, will speak on Thursday morning on the subject of alcoholism. He has written several articles on the subject.

Venereal disease and salmonellosis as well as alcoholism will be principal discussion topics.

Salmonellosis will be discussed at the opening session on Thursday morning. The speaker will be Dr. John R. Boring, assistant chief of the Veterinary Public Health Laboratory Unit at the Communicable Disease Center in Atlanta.

The program on Friday morning will be devoted to venereal diseases. Dr. Eugene Gillespie, deputy chief of the Venereal Disease Branch at CDC, will deliver the principal address on "Syphilis Eradication, U.S.A."

Three other speakers will explore various phases of venereal disease. They are Dr. Benjamin Schwimmer of the Health Department of Detroit; Mr. Warren T. Davis, Jr., chief of program services of the CDC's Venereal Disease Branch; and Dr. M. A. Viggiano, health officer for the Tyler-Wetzel-Monongalia County Health Departments. Doctor Viggiano's topic will be "Syphilis Eradication Program in West Virginia."

Afternoon sessions will be devoted to section meetings which include health administration, sanitation, health education and medical services, laboratory and industrial hygiene, mental health, dental health, nursing, and clerical and vital statistics.

Programs for section meetings will include a one-act play entitled "Sage Advice by Dr. Al Anon," produced by the Ohio County Mental Health Association. The play depicts the trials of a non-alcoholic spouse.

Other presentations for section meetings will include a talk on "Medical Quackery" by a speaker from the Food and Drug Administration; "Nursing Responsibilities in Venereal Disease" by Mary Romer, nurse training officer from CDC; a discussion of special sanitation problems; a dental health program, and a curbstone conference on laboratory procedures and problems.

The program on Friday will include a discussion of cleft lip and palate by Dr. Winston Frenzel, dental consultant of U. S. Public Health Service Region III.

The social program includes the executive council dinner, sanitarian's party, annual banquet, president's reception and dance.

Low Immunization Levels Attributed To Misunderstanding and Apathy

Misunderstanding of recommended immunization schedules and apathy or neglect account for almost all of the inadequately vaccinated children under age five in West Virginia, according to State Health Director N. H. Dyer.

Doctor Dyer, in a recent issue of the "State of the State's Health," discussed results of sample surveys of 2,298 families conducted in 29 counties under the Vaccination Assistance Project. He wrote that 64.2 per cent of the unimmunized families interviewed had not sought vaccine for their children because they thought of vaccinations as "school shots."

Neglect or apathy was the second most frequently mentioned reason, accounting for 21.8 per cent of the unimmunized.

Doctor Dyer pointed out that only .5 per cent of the unimmunized portion voiced religious objections; another 1.9 per cent gave financial reasons and 6.6 per cent said inadequate transportation prevented them from obtaining the vaccine. Of the remaining 4.9 per cent, the most frequently given reasons were fear, unawareness of need, or illness of the child.

Low levels of immunization were reported from all income levels. The most frequently mentioned occupations of the household head were laborer, miner, salesman, farmer, unemployed, mechanic, railroad worker, construction worker, factory worker and office worker.

He noted that the average number of persons in an unprotected household was five as compared to the state average of 3.5 persons per household.

The average educational level of the household head of those unimmunized families is 9 to 10th grades.

In another issue Doctor Dyer discussed morbidity data which indicate that the state may have a possible severe outbreak of measles during this year.

He pointed out that statistics from past years show that measles generally is a two-year cyclic disease. Last year's 10,330 cases represented a decrease from 1963's 14,273. Of the 1964 total, 5,220 cases, or more than half of the year's total, were reported in February, March and April.

For 1965 a total of 3,765 cases have been reported at the end of the first week of February. This represents 1,787 cases over 1964's total for January and the entire month of February. January's 2,800 cases in 1965 is almost three times the 1,067 cases in January, 1964.

Doctor Dyer urged parents to consult their family physician about having children vaccinated against measles.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

AMA Convention Will Have International Theme

The 114th annual convention of the American Medical Association in New York City, June 20-24, will have an international theme throughout the scientific programs.

"In keeping with the New York World's Fair, already drawing many thousands of foreign tourists to the city, the AMA has scheduled eminent foreign physicians to deliver lectures at the scientific meetings to be held during the convention," said J. Arnold Bargen, M. D., chairman of the AMA's Council on Postgraduate Programs. The Council directs planning of the scientific programs for the convention.

In addition to program participants, large delegations of physicians from many foreign nations will attend the convention and participate in the scientific sessions. Large groups from Japan, Mexico and many other nations already have indicated that they will attend.

"American physicians will have an opportunity at the New York convention to meet and mingle with other physicians from throughout the world, and to learn of current medical knowledge in other lands," said Doctor Bargen.

"We are proud of the fact that the United States now leads the world in medical science. Thousands of foreign doctors come to our shores every year for graduate study and training. More than 2,000 American physicians are serving in foreign lands as representatives for various governmental and private medical programs. Foreign physicians have much to learn from American medicine, and at the same time there is much that American doctors can learn from the many fine professional men in medical science in other lands," he said.

The New York World's Fair has been widely publicized throughout the United States and in the rest of the world. Many physicians, both from this nation and other lands, look to the June convention of the AMA as an oppotrunity to combine a visit to the World's Fair and intensive postgraduate study by means of the scientific lectures, films, color television and exhibits, Doctor Bargen said.

The six general scientific meetings of the convention will offer the latest research developments in adverse drug reactions; organ transplantation; hearing; nonnarcotic drug addiction; metabolism in growth development and aging, and diagnostic cytology.

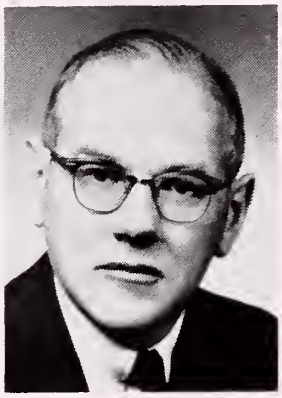
J. Banks Shepherd Receives Award

J. Banks Shepherd of Charleston, administrator of the group insurance program for the West Virginia State Medical Association, was given the award of Professional Excellence by the American Institute of Professional Association Group Insurance Administrators during a recent meeting of the Association in San Juan, Puerto Rico.

Mr. Shepherd, who is a member of the Executive Council of the Association, was presented the award in recognition of his agency's excellent record of quality service to clients.

18th Annual Oph. and Otol. Meeting At The Greenbrier, April 18-21

Dr. Arthur G. DeVoe of New York City will be among the speakers at the 18th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at the Greenbrier in White Sulphur Springs, April 18-21.


Arthur G. DeVoe, M. D.

Dr. R. Alan Fawcett of Wheeling, the President, will preside at the four-day meeting. He announced that the other guest speakers will be as follows:

Drs. Philip M. Lewis and Edwin W. Cocke of Memphis, Nathan S. Schlezinger of Philadelphia, David Austin of Chicago and David A. Dolowitz of Salt Lake City.

Physicians throughout the State have been invited to attend the meeting. A registration fee of $35 will cover all scientific sessions and social functions. Additional information may be obtained by writing the Secretary, Dr. Worthy W. McKinney, Professional Park, Beckley.

Mental Health Program in State Outlined in SK&F Journal

State Mental Health Director Mildred Mitchell-Bateman and her people-to-people program for the exchange of views on mental health are featured in the March-April issue of *SK&F Psychiatric Reporter*, which is published by Smith Kline & French Laboratories.

In an article entitled "Dr. Bateman Puts the Show on the Road," Author Joseph P. Coogan described a day-long Community Mental Health Regional Action Meeting at Martinsburg.

"If we're to make progress, we must travel up and down the state, hearing about many needs we already know are there, explaining what the state can do to meet these needs, and what can be done locally," Doctor Bateman told Mr. Coogan.

The regional meetings consisted of brief talks by Doctor Bateman and members of her staff, question and answer periods and panel discussions, Mr. Coogan wrote.

Reprints of the article may be obtained by writing Robert L. Dean, Editor; *SK&F Psychiatric Reporter*, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

If you are out to describe the truth, leave elegance to the tailor.—Albert Einstein.

Dr. James L. Cunningham Dies At Age of 101

Dr. James L. Cunningham, 101, of Pickens, Randolph County, died at St. Joseph's Hospital in Buckhannon on March 9.

Doctor Cunningham, who was born just two months and ten days after West Virginia became a State on June 20, 1863, was the oldest physician in West Virginia and one of the oldest in the United States at the time of his death. He had served as physician for hundreds of families in the Pickens - Helvetia - Hacker's Valley area from 1891 until his retirement several years ago.

James L. Cunningham, M. D.

A native of Pittsburgh, Doctor Cunningham taught school for seven years prior to entering medical school in 1888. He received his M.D. degree in 1891 from the Baltimore University Medical College.

Doctor Cunningham gained prominence in 1906 when he took care of George Rashid, a leper. Mr. Rashid was working as a railroad construction hand when it was discovered that he was suffering from leprosy. He was taken to Pickens where Doctor Cunningham treated him for 100 days prior to his death.

During his active life he was a member of the Board of Education and served as an observer for the U. S. Weather Bureau, and as election clerk and census taker.

He was an honorary life member of the Barbour-Randolph-Tucker Medical Society, West Virginia State Medical Association and American Medical Association.

He is survived by a daughter, Miss Mabel Cunningham of Pickens, and a sister, Mrs. Elizabeth Infield of Buckhannon. His wife died in 1956 and another daughter, Ethel, was a victim of polio.

Cleveland Hospitals Plan Symposium in May

More than 40 leading physicians, nurses and hospital administrators will participate in University Hospitals of Cleveland's Centennial Symposium which will be held in Cleveland, May 20-22.

The first day will be devoted to the functions and responsibilities of the university-affiliated teaching hospital in the community, graduate and undergraduate education and in research. Three critical areas of medical research—immunology, psychosomatic medicine and the population explosion—will be discussed on Friday morning, May 21. The remainder of the three-day meeting will be devoted to seven departmental meetings.

Survey Indicates Physicians Active In Mental Health Planning

A survey made several months ago has revealed that physicians throughout the State have been active in the program of the Governor's Advisory Committee for Mental Health Planning.

The survey was under the direction of Dr. L. J. Pace of Princeton, a past president of the State Medical Association, and Dr. William B. Rossman of Charleston, Chairman of the Association's Mental Health Committee.

Dr. Charles L. Goodhand of Parkersburg, immediate past president of the State Medical Association, was among the speakers at a conference on comprehensive programs for the mentally disabled, sponsored jointly by the West Virginia Department of Mental Health and the National Institute of Mental Health in June, 1964. The conference was under the direction of Dr. Mildred Mitchell-Bateman, Director of the West Virginia Department of Mental Health.

Other speakers included Dr. B. D. Smith of Clarksburg, vice chairman of the Governor's Advisory Committee, and Dr. Robert L. Vosburg, Professor and Chairman of the Department of Psychiatry at the WVU School of Medicine.

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, participated in several mental health planning programs and a number of practicing physicians are active in local committees and in groups cooperating with the various planning committees.

The Chairman of the Governor's Advisory Committee is Mrs. John W. Hash of Charleston, a past president of the Woman's Auxiliary to the Kanawha Medical Society. Nineteen physicians are members of the Committee and the following three physicians serve as Chairman of Task Force Committees: Drs. Frank J. Holroyd of Princeton, Joseph A. Smith of Dunbar and Doctor Pace.

Mrs. Louise B. Gerrard, research analyst in the Planning Division of the Department of Mental Health, announced that 43 per cent of the membership of the State Medical Association returned completed questionnaires in connection with the survey. The survey revealed that physicians agree that many patients are suffering from various kinds of mental illness and that physicians frequently see persons with physical illnesses associated with underlying emotional disturbances.

The key areas of physician concern are as follows. (1) Lack of community facilities adequate for the diagnosis and care of the mentally ill, and for maintenance of mental health; (2) Lack of fully-staffed institutions to treat the mentally ill; lack of institutions in areas accessible to the majority of the population of the State; and (3) Lack of appropriate community resources to facilitate care of returned mental patients, resulting in a high rate of readmission to state mental hospitals.

An analysis of the survey was mailed last month to all members of the Association and Doctor Rossman indicated he and other members of the Committee welcome comments and suggestions.

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File: Diarrhea

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1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
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Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

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SEARLE *Research in the Service of Medicine*

WVU Medical Center
–News–

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

THE School of Medicine at West Virginia University has accepted 62 students for the 1965 entering class. Dean Clark K. Sleeth said an eight-member Faculty Committee on Admissions worked five months to select the students from among 326 applicants.

Applicants, at first, were chosen from among more than 1,300 inquiries by prospective students. Every West Virginia resident who inquired was furnished with an application form. Applications, however, were sent to 20 per cent of the non-residents, who were screened according to college grades and aptitude tests.

Dean Sleeth said 84 students—61 of them from West Virginia—were offered places in the 1965 class. Later, 22 of them withdrew their applications. Eleven of these were West Virginians who chose to attend medical schools elsewhere.

Of the 62 students who will enroll this fall, 49 are residents of West Virginia. Others are from Maryland, Massachusetts, Michigan, New York and Pennsylvania.

The 62 students, in their undergraduate work in college, averaged better than a "B." Also, the group's performance on the nationwide Medical College Admissions Test was considerably better than average.

Among Mountain State cities, Charleston contributed the most students to the new class with seven. Six of the freshmen are from Morgantown, five from Huntington and five from Wheeling.

The breakdown by communities in West Virginia is as follows:

Huntington: Paul Akers, James Bobbitt, Theodore Haddox, Steven Moel and John Boso.

Wheeling: Harry Anderson, Henry Kettler, Donald Naegele, Richard O'Brien and Raymond Pierce.

Fairmont: Harold Bondy and Lawrence Morris.

Morgantown: Roy Carter, Juan Gutierrez, William Hall, Thomas Hobbs, William Mossburg and Richard Stevenson.

Charleston: Kay Burdette, Jack Burks, Richard Hawkins, Vincent Mazzella, James Richardson, Mary Shemo and Jonathan Tatomer.

Nitro: Mary Knapp and Lawrence Shivertaker.

St. Albans: James Castle, John Meadows and Roger Nichols.

Steve Caritis, Weirton; Ross Cline, Petersburg; Elliot Oaklander, Parkersburg; James Ballard, Gauley Bridge; Creel Cornwell, Lost Creek; Linda Frangowlakis, Williamson; Robert Gainer, Clarksburg; Emanuel Gaziano, Pemberton; Braden Griffn, St. Marys; William Hawley, Princeton; Gary Hazlett, Winfield; David Kappel, New Martinsville; Michael McNeer, Hinton; Robert Mace, Pickens; Robert Nerhood, Charles Town; Buford Rowe, Richwood; Margaret Staggers, Keyser; Jeff Seltz, Elkins; and Haven Wall, Rainelle.

Dr. Armand J. Quick to Speak

Dr. Armand J. Quick, an authority on blood coagulation, will deliver a lecture at the Medical Center on Friday afternoon, April 23, beginning at four o'clock.

Doctor Quick, who is emeritus professor of biochemistry at Marquette University, will present a paper on "Screening the Bleeding Patient for Coagulation Defects."

Doctor Quick is recognized for his contribution to the knowledge of hemorrhagic states and the mechanism of blood coagulation. In 1935, the "Quick One-Stage Prothrombin Time Test" was introduced which was a major step forward in the investigative techniques of blood coagulation.

The lecture will be sponsored by the Department of Pathology and the Medical Education for National Defense fund.

Doctor Esposito to Speak at Medical Center

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will speak before members of the faculty and students of the WVU School of Medicine at an assembly in the main auditorium of the Medical Center on Tuesday, April 6. The assembly will begin at 4:00 P.M.

Doctor Esposito also has accepted an invitation to speak at a dinner meeting of the Monongalia County Medical Society at the Hotel Morgan that evening.

Dr. Victor M. Napoli, Assistant Professor of Pathology, will present the last in a series of nine seminars on cancer research at the Medical Center on May 13. His subject will be "Unusual Aspects of Human Cancer."

Dr. Alvin L. Watne, cancer coordinator, said that the cancer seminars had been held to provide "a background of varied information for men of all academic pursuits."

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The Month in Washington

• **From the Washington Office of the American Medical Association.**

THE American Medical Association supports a five-year extension of the Vaccination Assistance Act. Dr. James Z. Appel, President-Elect of the AMA, and Dr. Robert C. Long, a member of the AMA Board of Trustees, presented the AMA's position on the vaccination program and three other health care bills at a hearing of the House Commerce Committee.

"Medicine, on the national, state, county, and community levels, has consistently worked to bring to its patients the benefit of advances in medical research and development," Doctor Appel said. The physicians of America and the Public Health Service have long been partners in the fight against disease and in the campaign to eradicate contagious disease wherever it is found.

Assistance Act of 1962

"The Vaccination Assistance Act of 1962 was enacted (with AMA support) in recognition of the fact that there existed all over the country pockets of people, particularly children, who were not utilizing, or who did not have available to them, vaccines for the prevention of poliomyelitis, diphtheria, whooping cough, and tetanus. The Act authorizes grants to the states to enable them to engage in a concentrated campaign to provide immunization to people in these pockets. We believe that substantial progress has been made, and we recommend the program's continuation.

"Medical research has since (1962) provided an effective vaccine against measles. An intensive vaccination program directed at preschool age children can dramatically lessen the incidence of the disease and reduce or eliminate the serious residual effects which are sometimes attendant with the disease. We therefore believe that it is most fitting that in extending the Vaccination Act, H.R. 2986 include measles in the authorized vaccination programs."

The AMA also supported a five-year extension of the federal grant program for family health services for migratory workers.

The AMA opposed legislation that would authorize the Public Health Service to construct and operate regional or national research facilities. Doctor Appel said:

"We fail to see how research can be classified as 'regional' or 'national' or 'local'. Research in cancer which may be carried on in a medical school research facility in a midwestern city is as 'national' in character as if it were carried on in a city on the west coast. Research in heart disease, or in any of the many areas of interest to medical science, has no geographic bounds . . .

"We believe that the country will best be served through the utilization of the experience and knowledge of institutions which are currently engaged in medical research. Their record is a good one. We see no reason for beginning a new program which would require many months or years and large sums of money, and which would compete for scarce skilled research manpower . . ."

Community Health Centers

Doctor Long outlined the AMA's opposition to use of federal matching funds for initial staffing of community health centers.

"We believe that once the center has been constructed, the community should assume the remaining responsibility," Doctor Long said.

"The providing of medical care is essentially a community affair. The federal government's participation in a matching grant program stimulates the start of the local program and helps the state or community overcome the initial heavy financial burden. Most often, the problem initially facing a community is the one-time large construction-cost expenditure. Assistance here, by way of federal matching grants, is, in our opinion, appropriate. The funds for staffing, however, should remain the sole responsibility of the local community. There does not appear to be any justification for federal participation in financing this type of expense, nor is it likely to phase out, as stated in the bill, once the federal government has assumed this responsibility. If the community cannot, or will not, support the program from its beginning years, it is not likely to do so later."

As for legislation that would authorize federal mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine and dentistry, the AMA said:

"The bill specifies that the surgeon general shall give preference to, in effect, closed panel prepaid group health plans. This priority discriminates against other physicians in private practice either as solo practitioners or in partnerships or groups."

Obituaries

HAROLD D. GUNNING, M. D.

Dr. Harold D. Gunning, 75, of Fairlea, Greenbrier County, died on February 25 at his home in that community after a long illness.

He was born on May 8, 1890, in Marshall, Wisconsin, the son of the late Robert and Margaret Gunning. He was graduated from Marquette University and received his M. D. degree in 1918 from the Loyola University School of Medicine. He was licensed to practice in West Virginia that same year.

He was co-owner of the Greenbrier Valley Hospital in Ronceverte from 1927 until his retirement in 1949, and he was an honorary life member of the Greenbrier Valley Medical Society, The West Virginia State Medical Association, and the American Medical Association.

Besides his widow, he is survived by two daughters, Mrs. W. F. Schueler of Pompano Beach, Florida, and Mrs. W. G. Garrett of South Charleston; and three grandchildren.

* * * *

ARTHUR L. JONES, M. D.

Dr. Arthur L. Jones, 75, of Wheeling, died on January 29 in that city.

He was born on June 28, 1889, in Mannington, the son of David C. and Alice M. Jones. He attended West Virginia University and received his M. D. degree in 1919 from the Jefferson Medical College of Philadelphia.

He served his internship at Ohio Valley General Hospital in Wheeling, 1919-20, and had postgraduate training in urology at the University of Pennsylvania Graduate School of Medicine.

He served a term as president of the Ohio County Medical Society and was an honorary life member of the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Marjorie Brock of Wilmington, Delaware; a sister, Mrs. Wayman Robinson of Mannington; three brothers, Chester W. Jones of Shinnston, Virgil L. Jones of Clarksburg, and Roy V. Jones of Green Mountain Falls, Colorado; and four grandchildren.

* * * *

PAUL ERNEST TOTTEN, M. D.

Dr. Paul Ernest Totten, 44, of St. Albans, died on February 24 at a hospital in South Charleston.

Doctor Totten was born in Charleston on May 4, 1920, and was graduated from Morris Harvey College. He received his M. D. degree in 1951 from the Medical College of Virginia and served an internship at Charleston General Hospital, 1951-52.

He served as a Lieutenant in the United States Army during World War II and was awarded the Bronze

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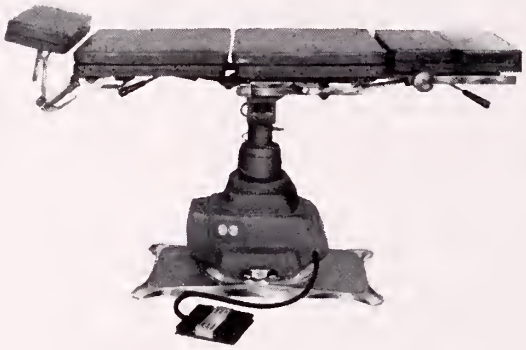

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Star. He was a member of the 82nd and the 101st Airborne Divisions.

Doctor Totten was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by his father, E. N. Totten of St. Albans; three daughters, Nancy, Diane and Sally, at home; two sons, Charles and David Totten, at home; one sister, Mrs. Mary Ollene Bailey of Charleston; and one brother, Melville Totten of St. Albans.

* * * *

SIDNEY F. YOHO, M. D.

Dr. Sidney F. Yoho, 85, of Moundsville, died on February 25 at a hospital in Wheeling following a long illness.

Doctor Yoho, who served as physician at the West Virginia Penitentiary in Moundsville for 20 years, was born in Woodlands, Marshall County, the son of Francis V. and Talitha Biddle Yoho. He received his M. D. degree in 1904 from the University of the South Medical School in Nashville. He served his internship at Haskins Hospital in Wheeling.

He practiced in Cresaps from 1919 until 1933 when he moved to Moundsville. He served for 20 years as examining physician for the Selective Service Board in Marshall County and during World War I he served with the U. S. Public Health Service in Nitro. He was an honorary life member of the Marshall County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by two sons, Sidney, Jr., and Francis, both at home.

38-Million Persons Protected By Health Insurance

Individual and family health insurance policies issued by insurance companies protect nearly 15 million more people today than they did 10 years ago, according to the Health Insurance Institute. The Institute said that in 1953, companies provided programs to 23,475,000 Americans; in 1963, the number protected that year totaled 38,065,000, an all-time high. The increase represents a rise of 62 per cent over the 10-year span.

In insurance terminology, the term "individual" when applied to health care protection, includes family type policies. It is a type of protection distinct from "group" type of insurance usually obtained at places of employment. (A total of 60,547,000 persons were protected under insurance company group programs at the end of 1963).

The Institute reported that individual health insurance coverages are playing an increasingly important role in the financing of health care in the United States. A total of 821 insurance companies issued individual policies in 1963, an increase of 26 per cent over the number of companies providing this protection in 1958, and a 68 per cent growth over the 490 companies issuing individual policies in 1953.

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References: (1) Warres, H. L.: *Missouri Med.* 61:27, Jan., 1964. **(2)** Palmer, K. J.: *Week. Urol. Clin. Letter* vol. 6, no. 36, Dec. 24, 1962. **(3)** Carroll, G.: *J. Urol.* 90:476, Oct., 1963. **(4)** Ward-McQuaid, J. F. N. C.; Jichlinski, D., and Macis, R.: *Brit. M. J.* 2:1311, Nov. 23, 1963.

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

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County Societies

CABELL

Seventy-one members and guests attended the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on February 11.

Dr. Rowland H. Burns opened a panel discussion on "The Concept of Area Medical Planning and Preparation for Medical Practice of the Future." Other participants included Dr. D. Sheffer Clark; Mr. Larry Ferris, administrator of Cabell-Huntington Hospital; and Mr. Steve Soltis, executive director of St. Mary's Hospital.

On motion by Dr. William L. Neal, the Society went on record as supporting the principles of the Eldercare Program, which is supported by the American Medical Association.

Dr. J. Marshall Carter reported that usage of Blue Cross coverage in Huntington increased 23 per cent from 1963 to 1964, with an increase of only two per cent in subscribers.

Mrs. Margaret Ann Collins, national president of the Mended Hearts Association, was introduced to members of the Society by Dr. Gerald J. Eder.

The Society elected Dr. Florence Hoback to membership and Dr. Bruce H. Pollock was elected to honorary membership.—Harold N. Kagan, M. D., Secretary.

* * * *

FAYETTE

Dr. William D. McLean of Beckley was the guest speaker at the monthly meeting of the Fayette County Medical Society on March 3 at the Edgewater Motel in Gauley Bridge.

Dr. D. Alene Blake, president of the society, introduced Doctor McLean, who gave an interesting talk on common skin diseases. His presentation was illustrated with slides. A question and answer and general discussion period followed.

The monthly meeting also included a dinner and brief business session.—W. P. Bittinger, M. D., Secretary.

* * * *

LOGAN

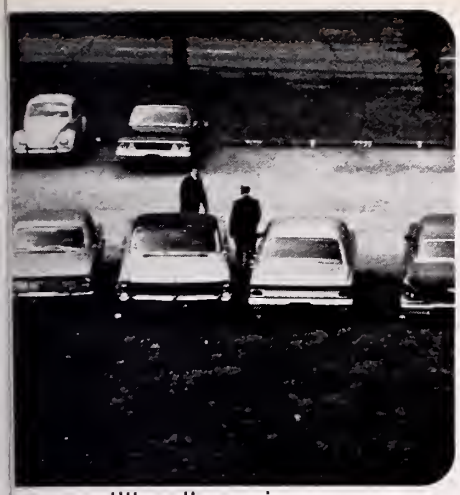
Dr. Hans W. Dransfeld of Huntington was the speaker at the regular monthly meeting of the Logan County Medical Society which was held at the Appalachian Power Company Auditorium in Logan on February 10.

Doctor Dransfeld presented an interesting paper on "Radioisotope Scanning of Various Organs of the Body." His presentation was followed by a question-and-answer period.—Kwan Ho Lee, M. D., Secretary-Treasurer.

* * * *

MONONGALIA

Dr. C. N. Joseph Chang of the Department of Radiology, West Virginia University Medical Center,



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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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spoke at the monthly meeting of the Monongalia County Medical Society which was held on February 2 in Morgantown.

Doctor Chang gave an illustrated talk on "Mammography" and told how this technique is improving the diagnosis of breast cancer and other breast diseases.

The Society voted to donate $500 to the State Diabetic Camp for needy children. That sum was left over from polio immunization contributions.—William E. King, M. D., Secretary.

* * * *

McDOWELL

The monthly meeting of the McDowell County Medical Society was held on February 10 at Grace Hospital in Welch.

Dr. Ross Miller of Grace Hospital gave an interesting talk on jaundice and the various physiopathologic aspects concerned in the diagnosis of biliary hepatic disease with jaundice.

Drs. A. J. Villani and J. Hunter Smith discussed bills pending in the Legislature. There was also a discussion of the American Medical Association's "Eldercare" program.

Drs. Ebb Whitley and J. C. Ray were elected to membership in the Society.—David J. Skewes, M. D., Secretary.

MERCER

Dr. N. Allen Dyer was the speaker at the regular monthly meeting of the Mercer County Medical Society on February 15.

Dr. John J. Mahood, secretary of the Society, introduced Doctor Dyer, who presented an interesting paper on hypertension.

The Mercer County Medical Society voted to donate $70 to Camp Kno-Koma during the regular monthly meeting which was held at the West Virginian Hotel in Bluefield on March 15.

Doctor Mahood explained the vaccination assistance program. He said that beginning April 1, a health educational campaign would be launched to urge vaccination of pre-school children.—John J. Mahood, M. D., Secretary.

* * * *

WYOMING

Dr. Sherl J. Winter of Beckley was the guest speaker at a joint meeting of the Wyoming County Medical Society and the Woman's Auxiliary at the Wyoming Hotel in Mullens on March 7.

Doctor Winter presented an interesting paper on "Electrolytes in Children."

Dr. Frank J. Zsoldos, the president, presided at the meeting which was attended by 11 physicians and six members of the Auxiliary.—Ross E. Newman, M. D., Secretary.

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AUXILIARY MEETING IN NEW YORK

The 42nd Annual Convention of the Woman's Auxiliary to the American Medical Association will be held in New York City, June 20-24.

The headquarters hotel, The Americana, has set aside a limited number of rooms for members of the Woman's Auxiliary. The deadline for making reservations at The Americana is April 15.

Reservations for rooms at The Americana and other hotels listed in *The AMA News* and *JAMA* should be made on the official Auxiliary form in the March Bulletin. Members of the Auxiliary should identify themselves as such to receive special consideration.

KANAWHA

The Kanawha County Medical Auxiliary has allocated $2,221 among six causes from a special Christmas fund.

For several years the Kanawha Auxiliary—in place of sending Christmas cards to doctors' families—has been contributing to a special fund to help others. This year the fund was divided among AMA-ERF, health centers, hearing program, mental health, Camp Galahad and the Morris Harvey School of Nursing.

Mrs. Travers R. Harrington, executive director of the Kanawha Council for Retarded Children, was the speaker at the February meeting which was attended by 42 members and guests. Her topic was "Mental Retardation—A Challenge to the Community."—Mrs. Arthur A. Abplanalp, Publicity Chairman.

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RALEIGH

Mrs. Walter Griswold was the guest speaker at the February luncheon meeting of the Auxiliary of the Raleigh County Medical Society at the Beckley Hotel.

Wearing a Hawaiian costume, Mrs. Griswold gave an interesting talk on the people, dress, customs and other aspects of the island state. She also displayed several unusual items she had acquired while living in Hawaii.

More than 33 members and guests attended the luncheon meeting.—Mrs. John E. McKenzie, Publicity Chairman.

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Book Reviews

SYNOPSIS OF CLINICAL TROPICAL MEDICINE—By Lt. Col. Oscar Felsenfeld, (MC) U. S. Army; Associate, Department of Experimental Pathology, Walter Reed Army Medical Center, Washington, D. C. Pp. 378, with illustrations. C. V. Mosby Company, St. Louis. 1965. Price: $9.85.

Brigadier General C. L. Milburn, Jr., in the Foreword to this book states that "Tropical Medicine is concerned with diseases that currently are restricted to, or are prevalent in, the tropics." He later adds that "In this age of rapid transportation by air, the reintroduction of communicable diseases into areas once rid of them is distinctly possible."

Lt. Col. Felsenfeld has drawn upon a wide range of experiences for this *Synopsis of Clinical Tropical Medicine*. As the title indicates the text is largely concerned with clinical aspects of each disease. He discusses the microbiologic and epidemiologic aspects only lightly. The brevity of this synopsis is both its advantage and disadvantage. It provides a rapid summarization of basic facts about tropical infectious diseases, insect and animal bites, irritating and poisonous plants and chemicals, effects of heat, nutritional disorders, and anemias. For depth in any of these topics one is still advised to refer to standard texts.—Ernest W. Chick, M. D.

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Pierce D. Nelson, M. D.
Phone: 328-2211

AETIOLOGY OF DIABETES MELLITUS AND ITS COMPLICATIONS—By Margaret P. Cameron, M. A., and Maeve O'Connor, B. A. Little, Brown and Company, Boston. 1964. Pp. 405. Illustrated. Price: $12.50.

An up-to-date survey of the basic aspects of recent diabetes mellitus research is presented in this Ciba Foundation Colloquia. The world's leading diabetologists are brought together informally. They each present or re-present their recent investigative work, then discuss, criticize and question one another. Except for the one year time lag from meeting to publication, this book offers more digestible material than the meeting itself. Obviously, the answer offered by the book's title is not forthcoming but information is presented which will be of interest to the physician at any degree of sophistication.

The importance of diabetes is first pointed out by reporting a 5 per cent and up to a 14 per cent incidence of diabetes in community studies. The concept in this book is that diabetes is a condition which only secondarily involves the islets of Langerhans. Initially the islets are stimulated to hypertrophy and show signs of inflammation and later hyaline deposition occurs. The hyaline material may be a product of increased beta granule disintegration as increased liberation of insulin is demanded. The morphologic process of insulin liberation is described from electron microscopic studies.

A multifacited presentation of the plasma immunoassayable insulin and insulin-like activity as measured by fat pad or diaphragm information is compiled. This generally shows increased circulating insulin and insulin-like activity with increased blood glucose levels and even greater insulin levels at comparable blood glucose levels in the recently diagnosed diabetic. This is further evidence that islet stimulation occurs in early diabetes. An inherited plasma protein insulin antagonizing factor which can be demonstrated in diabetes and pre-diabetes may result in compensatory islet stimulation.

Other investigations suggest this plasma protein factor may be secondary to increased insulin degradation. The factors of insulin antagonism seem to be dependent on the pituitary and adrenals for their origin. Of great interest is the evidence for more than one form of circulating insulin which may function differently in different tissues.

Another factor which is considered to cause insulin insensitivity is elevated plasma levels of non-esterified fatty acid. The plasma non-esterified fatty acids are an index of adipose tissue catabolism, a process which is reversed by insulin. The feedback mechanism suggested between non-esterified fatty acids and insulin acting through adipose tissue is a subject which will require further exploration.

The relation of diabetes to angiopathy of various sorts is the basic concern of physicians dealing with diabetics. Items of special interest from this meeting

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include evidence for increased collagen aging due to a disturbance in carbohydrate metabolism and the suggestion that lathyritic agents may be found to retard this aging. The suggestion is made that the thickened basement membrane of the diabetic's vessels is secondary to excess hexose availability for non-insulin requiring glycoprotein formation. That this is a function of duration as well as degree of disturbed carbohydrate metabolism is shown by the increased basement membrane thickness seen early in maturity-onset diabetes as compared with early juvenile diabetes. The observation that similar changes and microaneurysms are found in prolonged secondary diabetes; i.e., following pancreatitis or hemochromatosis, is evidence that these are not a part of genetic diabetes alone. In addition to the thickened basement membranes the disturbed carbohydrate metabolism causes loss of the supporting mural cells and permits microaneurysmal development.—Paul Davidson, M. D.

Books Received

SIMPLE SPLINTING—By Jerome Rotstein, M. D., Head, Rheumatic Disease Unit, Montefiore Hospital; and Consultant in Arthritis, Beth Abraham, New York, N. Y. Pp. 126, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1965. Price $6.50.

★ ★ ★ ★

FUNDAMENTALS OF ORTHOPAEDICS—By John J. Gartland, A. B., M. D., Assistant Professor of Orthopaedic Surgery, Jefferson Medical College. Pp. 338 with illustrations. W. B. Saunders Company, Philadelphia, and London. 1965. Price: $8.00.

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WANTED—General practitioner for small community and large surrounding farming area—near coal mines. Good roads and modern conveniences. Retired physician with fifty years experience in general practice and the citizens are interested in helping a physician and believe that the locality offers many advantages. Contact Dr. A. O. Kelly, Wallace, W. Va. Phone 796-3910.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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AVAILABLE—Board eligible OB-GYN specialist; 30 years of age, married and 2 children. Residency training at Philadelphia General Hospital and currently completing service obligation. Available in August, 1965 and interested in association or group practice in West Virginia. Write BMT, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Physicians needed to take over established practice of deceased physician. Modern office available in community located in Southern West Virginia. Trading population of 75,000. Splendid opportunity for one or more physicians. Contact BLW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Anesthesiologist desires to locate in West Virginia upon completion of training in June, 1965. Nine years experience in general practice. Foreign graduate and licensed in West Virginia. Write LAC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

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PHYSICIAN WANTED—Physician trained in obstetrics or with special interest in obstetrics to do mostly obstetrics and some general practice in association with qualified man in group. Excellent guarantee and a good future. Write NNN, The West Virginia Medical Journal, Box 1031, Charleston, W. Va.

WANTED—General practitioner in Richwood. Citizens of this community are interested in helping physician and believe that the locality can offer an ambitious doctor many advantages. Contact Sr. M. Pia, C.M.P., Administrator, Sacred Heart Hospital, Richwood, W. Va.

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The West Virginia Medical Journal

May, 1965 Vol. 61, No. 5

Blastomycosis in West Virginia

Alfred K. Pfister, M. D., Beatrice H. Kuhn, M. D., A. B. Curry Ellison, M. D., and James H. Walker, M. D.

Much progress has been made both in the understanding and treatment of North American blastomycosis since Gilchrist's original description of the causative organism more than a half-century ago.[1] Although the disease occurs infrequently, it is by no means rare. The majority of case reports, well over 700, are from east of the Mississippi River. More often than not, the ailment is sporadic in occurrence although it has been known to occur epidemically.[2] It is thought but not yet conclusively established that the organism *Blastomyces dermatitidis* gains inoculation by the respiratory route in man, although primary inoculation through the skin has been reported in rare instances.[3]

The purpose of this paper is to review our clinical experience with the disease over the past ten years and to discuss collected observations in the literature pertaining to our cases. A review of current trends of therapy is included.

During a ten-year period we have observed 12 patients hospitalized with blastomycosis (Table 1). There were 8 males and 4 females. Age range of the males was from 53 to 71 years except in the case of one patient who was 41. Age range of females was 38 to 51 years. Although several of these patients were miners, by the nature of our occupational area, we were not able to form any implications on epidemiological grounds.

Exists in Two Forms

North American blastomycosis exists as a systemic form and as a primary cutaneous form. The systemic form has its initial focus in the lungs and disseminates by hematogenous routes to other organs. It was thought formerly that systemic disease in blastomycosis was primarily cutaneous in origin. Schwarz and Baum,[4] however, in 1951, concluded, after thorough autopsy studies, that systemic blastomycosis originates in the pulmonary system and involves the skin and other organs secondarily. There are only four accepted cases reported in the literature in which there was primary cutaneous inoculation, and dissemination occurred in none of the four.[3]

Although blastomycosis has its origin primarily in the lungs, many patients may have disseminated disease and normal chest x-rays. This indicates that there can be a considerable lag between the initial pulmonary findings and the actual presenting complaints, allowing the pulmonary manifestations to regress and escape radiographic detection.

In our series of 12 cases, there were only 2 in which the patient had a normal chest x-ray. Of the remaining 10 cases, there were 7 in which we were able, by sputum culture or lung biopsy, to document the lesion as being definitely mycotic in origin.

Case 7 illustrates the transient manifestations of the disease rather well. Approximately 5

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Submitted to the Publication Committee, October 23, 1964.

TABLE 1
SUMMARY OF HOSPITALIZED PATIENTS WITH BLASTOMYCOSIS

A more detailed discussion involving a few cases is included in the text.

Number Case	*Patient Status*	*Established Diagnosis By*	*Organs Affected*	*Immunological#*	*Therapy and Result*	*Comment*
1.	71 yr. old white male former miner (Kanawha County)	Thoracotomy and lung biopsy	Lungs and skin	Blasto (−)	Had 3 courses of 2-hydroxystilbamidine (2250 mgms. each); four recurrences in 5 years.	Genito-urinary symptoms but IVP's were normal. Transurethral resection tissue showed no histological evidence of involvement. Third recurrence was pneumonic; last recurrence was cutaneous, almost four years after chest lesions treated.
2.	45 year old white female housewife (Boone County)	Skin biopsy	Skin on right lower leg	N. P.	Surgical excision and irradiation unsuccessful; amphotericin B (1.5 gms.) given without recurrence.	Chest X-ray was unremarkable; long bones of right leg negative.
3.	56 year old white male miner (Kanawha County)	Thoracotomy	Lungs	Blasto (−) Histo (−) Tbc (−)	Partial resection involving right upper and middle lobes; course of 2-hydroxystilbamidine given.	Presented with a nonproductive cough, weight loss and malaise. Bronchoscopy showed deformity of right upper lobe orifice; pre-operative diagnosis was probable carcinoma of lung.
4.	56 yr. old white male contractor (Webster County)	Sputum culture	Lungs	N. P. Tbc (−)	Expired prior to diagnosis.	Two month history of cough productive of white sputum, then had hemoptysis, fever and 30 lb. weight loss. Bronchograms revealed bronchiectasis. Expired from a myocardial infarction.
5.	53 year old white male lumber jack (Raleigh County)	Skin biopsy and positive smear of skin lesion	Skin	Blasto (−) Histo (−) Tbc (−) *C. F. T.:* $Co_y = 0$ $Hi_y = 0$ $Hi_m = 0$ $Bl_y = 0$	Two grams of amphotericin B given; no recurrence—14 months.	Cough productive of yellowish sputum for 1 yr. Calcified scattered nodules on chest film. Normal IVP; negative prostatic smear.
6.	51 year old white female housewife (Lincoln County)	Skin biopsy, bronchial biopsy and sputum	Lungs and skin	N. P.	Irradiation to lip lesion; 2.1 gms. of Stilbamidine given.	Four month history of malaise, cough, pleuritic pain and anorexia. Chest film showed fibrotic hilar infiltrate with atelectatic right upper lobe, the latter clearing with treatment.
7.	41 year old white female waitress (Logan County)	Positive sputum culture	Lungs	Blasto (−) Histo (+) Tbc (−) *C. F. T.:* $Co_y = 0$ $Hi_y = 0$ $Hi_m = 0$ $Bl_y = 0$	Currently being treated with amphotericin B.	History of cough productive of whitish sputum, weight loss and fatigue five months previously which cleared spontaneously over a few weeks. Chest film showed bilateral nodular infiltrates.
8.	41 yr. old white male coal miner (Raleigh County)	Skin biopsy	Skin	Blasto (+) Desensitized with vaccine	Irradiation and 1500 mgms. Stilbamidine therapy.	Claimed that lesion had been indolent for at least 2 years; chest X-ray showed bilateral hilar fibrosis.
9.	63 yr. old white male (Fayette County)	Skin biopsy	Lungs, skin, brain, liver, spleen, kidneys, adrenals and other organs	N. P.	One infusion of 2-hydroxystilbamidine (225 mgms.) was given. Expired shortly after the diagnosis.	Several month history of fever, arthralgia, chills and cough. Bilateral nodular infiltrate on chest film. Dermal lesions appearing two weeks prior to admission.
10.	71 year old white male coal miner (Kanawha County)	Skin biopsy	Skin	Blasto (−) Histo (+) Tbc (−) *C. F. T.:* $Co_y = 0$ $Hi_y = 1/16$ $Hi_m = 0$ $Bl_y = 1/16$	Surgical excision of small lesion on nose; no recurrence after 14 months.	Asymptomatic except for slowly enlarging lesion of nose for several weeks. Bilateral calcified nodules on chest film with areas of fibrosis.
11.	56 year old white male miner (Raleigh County)	Positive sputum and skin biopsy	Lungs and skin	Blasto (+)	4.0 gms. of 2-hydroxystilbamidine given without clearing.	Was previously hospitalized in tuberculosis sanitarium; three year history of bronchitis with white sputum. Dermal lesions began three months prior to admission, over face and extremities. Chest film showed fibrous infiltrate with blebs.
12.	38 yr. old white female (Clay County)	Skin biopsy	Skin	Blasto (+) requiring desensitization with vaccine	Over an eight year period had 3100 mg. Stilbamidine and over 9500 mgms. of 2-hydroxystilbamidine. Nine recurrences.	Pustular lesions began on legs 1½ years before treatment. Chest X-ray and bone survey negative during entire interval.

#—Blasto—Blastomycin skin test
Histo—Histoplasmin skin test
Tbc—Purified protein derivative, tuberculin, intermediate strength
C. F. T.—Complement-fixation test

Co_y—yeast-phase antibody titer for Coccidiodes immitis
Hi_y—yeast-phase antibody titer for Histoplasmosis capsulatum
Hi_m—mycelial-phase antibody titer for Histoplasmosis capsulatum
Bl_y—yeast-phase antibody titer for Blastomyces dermatitidis

months prior to her admission, the patient had a nodular infiltrate in both lung fields following an episode of lower respiratory tract complaints. Multiple sputum cultures were performed and only one yielded the organism *Blastomyces dermatitidis.* When she was admitted her chest film showed considerable clearing of the pulmonary lesions without therapy (Figure 1). In spite of her being asymptomatic at the time of admission, amphotericin B treatment was instituted because blastomycosis may become manifest years later even though the initial clinical symptoms have abated completely.

Systemic Form

The systemic form may present itself in no characteristic manner. It may occur without any demonstrable pulmonary or cutaneous lesions. In decreasing order the skin, lungs, subcutaneous tissue, bones and genito-urinary system are the most frequent sites involved.[5, 6] In all of our cases either the lungs or the skin, and frequently both, were affected.

In approximately two-thirds of our cases, the patient presented with lower respiratory system complaints (Table 1) ranging from two months to several years' duration. This is a much higher incidence when compared with a series of 40 cases, in only 6 of which the patient had initial complaints referable to the respiratory system, although in over half of the 40 cases he did have respiratory complaints when specifically questioned.[5] Our high incidence can be explained by the fact that these patients were referred with a more unusual type of pulmonary disease as well as by the fact a higher occupational hazard in our area.

Dermatologic Picture

The dermatologic picture is quite variable in time and in appearance. In our cases, skin lesions appeared from a few weeks to eighteen months before institution of therapy. In the majority, however, the lesion appeared within two months. Usually it starts as a papulopustule on the face or the extremities and slowly enlarges into a verrucous, ulcerating granuloma. As it spreads peripherally in a serpiginous manner, there is central healing, leaving an atrophic scar. The raised and crusted edges of the lesion contain many miliary abscesses from which the organism may be expressed easily to smear or culture (Figure 2). Regional adenopathy occurs only in those cases with primary cutaneous inoculation unless there is an underlying bacterial infection of an open lesion. It is important to note that the subcutaneous tissue may be involved and may drain into the skin subsequently, forming a sinus.

Figure 1-a

Figure 1-b

Figure 1-a. These chest x-rays serve to illustrate the natural history of pulmonary lesions in North American blastomycosis. A nodular pulmonary infiltrate (chest film on left) was present when the patient had an episode of lower respiratory tract symptoms. Figure 1-b. At the time of admission, five months later, a repeat chest x-ray showed considerable clearing without therapy.

There is no specific presenting pattern in this disease. Nonspecific symptoms such as fever, chills, night sweats, malaise and weight loss occurred in one-third of our cases. In Case 1, the patient had been treated twice previously over a twenty-month period and presented clinically the third time as an acute pneumonia (Figure 3). Initially this was treated as having a bacterial cause without response, but after its etiology was confirmed, 2-hydroxystilbamidine therapy was started and there was clearing of the pulmonary lesion over a three-week period. Cases 3 and 10 were initially considered to have bronchogenic carcinoma because of symptomatology and x-ray findings; one necessitated thoracotomy, and the other, bronchoscopy and multiple sputum cultures to confirm the diagnosis. In the entire series, there was but one instance of central nervous system and genito-urinary involvement.

As mentioned previously, in almost all of our cases, the patient had an abnormal chest x-ray. Hilar thickening and fibrosis were common. Nodular infiltration, consolidation, blebs, cystic areas and mass lesions—all were seen. Calcification is said not to be a manifestation of pulmonary blastomycosis.[5] It was present in two instances (Cases 5 and 10) but probably was due to previous histoplasmosis infection. Immunologically, this could be documented in Case 10.

Involvement of the osseous system gives the appearance of bone destruction with virtually no evidence of bone proliferation.[6] The ribs and the vertebrae are commonly involved, but lesions occur in the long bones, skull, knee and elbow joints to a lesser extent.[7] In our cases there were no known instances in which bones were involved; bone involvement, however, was not searched for consistently.

Diagnosis

Frequently the diagnosis by isolation of the organism is quite difficult. No one method should be relied upon. Skin biopsies and sputum cultures were the most helpful in our cases. Cultures and smears of skin lesions, prostatic secretions and bronchial washings also have proved to be of benefit in establishing the diagnosis. Because of the frequent involvement of the genito-urinary tract, urine cultures should be performed when evidence of systemic disease or abnormal urinary sediment is present. In more unusual cases, blood cultures may be positive. Bronchial biopsies, although they may infrequently show the organism, may give histological support to the diagnosis.

Blastomycin Skin Test

The blastomycin skin test has not proved to be of much value in establishing the diagnosis because it frequently is negative in patients with active disease. It should be performed simultaneously with other fungal skin tests because of antigenic cross reactions. Of 8 patients tested in our series only 3 had a positive reaction.

The skin test and the complement fixation test have been shown to be of prognostic value.[8] The complement fixation titer reflects the number of proliferating organisms more than immunologic resistance. Patients with a negative skin test and a positive complement fixation titer have the poorest prognosis. Those with a positive skin test and a negative complement fixation titer have the best outlook. In patients with disease of recent onset, both tests often are negative, while patients with far advanced and extensive disease frequently show positive reactions to both tests. All fungal antigens should be employed in the complement fixation test because of cross reactions. Serum for serologic testing should be drawn prior to skin testing because the intradermal antigens may falsely elevate complement-fixing antibodies.[9]

In Case 10 the patient had a cutaneous lesion for blastomycosis removed. His chest x-ray showed scattered bilateral calcific densities suggesting a previous histoplasmosis infection. The skin test was positive for histoplasmin only. Complement fixation titers showed elevations to the same degree in the yeast phase both for histoplasmosis and Blastomyces. An elevated yeast titer is more indicative of active histo-

Figure 2. Cutaneous growth occurring in systemic blastomycosis. Notice the central healing and disfiguration as the lesion spreads peripherally.

Figure 3. Blastomycotic infiltrate in the right lower lung field. Clinically, this patient presented as an acute bacterial pneumonia.

plasmosis infection than the mycelial phase in the complement fixation test.[9] Continued observation of our patient has not revealed any further disease.

Treatment

Until the advent of effective chemotherapy in recent years, treatment for this disease was generally disappointing. Irradiation, desensitization with Blastomyces vaccine of those patients with a positive skin test, iodide administration and selected resection of involved areas were the mainstays of therapy prior to the introduction of the aromatic diamidines in 1951. Stilbamidine was used initially but because of a significant incidence of neuropathy, 2-hydroxystilbamidine became the drug of choice. Although the latter drug displayed much less toxicity and was equally effective, recurrence with the emergence of resistant forms of the organism was noted in some instances.

Amphotericin B was introduced in 1957 and gained acceptance as an effective clinical fungicidal agent for blastomycosis. Both the cutaneous and pulmonary lesions cleared more rapidly than with the use of the aromatic diamidines. With larger groups of patients studied,[10, 11] however, recurrence under amphotericin B therapy also was apparent.

Toxicity

It soon became evident that amphotericin B was much more toxic than 2-hydroxystilbamidine. Nausea, vomiting, chills and fever were observed in the majority of patients receiving amphotericin B infusions; these reactions were controlled fairly well by premedication. Hypokalemia, anemia and increased bromosulfophthalein retention occurred less commonly. Mild to moderate azotemia and abnormal urinary sediment appear during the course of amphotericin B therapy. They can be controlled to some extent by giving the infusions every two to three days. More recently it has been shown that permanent functional and histological renal changes may result.[12]

Due to the toxicity of amphotericin B, Lockwood et al[13] have re-evaluated 2-hydroxystilbamidine therapy in blastomycosis, showing it to be equally effective and less toxic than amphotericin B. They and others[11] presently consider 2-hydroxystilbamidine to be the drug of choice. In view of these reports,[10-13] we too consider 2-hydroxystilbamidine as the initial drug in the treatment of North American blastomycosis. Patients severely ill with systemic disease or patients with recurrence after 2-hydroxystilbamidine therapy are more likely candidates for amphotericin B therapy.

Summary

A series of 12 cases of the systemic form of North American blastomycosis admitted to a West Virginia hospital over a 10-year period is reviewed.

In accordance with findings from other studies that blastomycosis originates in the pulmonary system, involving the skin and other organs secondarily, our study showed that in 10 of our 12 cases the patient had an abnormal chest x-ray. In the entire series the lungs or the skin, or both, were affected. Skin lesions were variable both in time and in appearance.

Diagnosis requires a variety of approaches but in our experience skin biopsies and sputum cultures were most useful.

Skin tests and complement fixation tests are of value in determining prognosis. Treatment has become more promising in recent years with the advent of effective chemotherapy. Amphotericin B and 2-hydroxystilbamidine both are excellent fungicidal agents. Advantages found in the more rapid clearing of lesions by the use of amphotericin B are offset by its higher incidence of toxicity and, in the cases reviewed in the literature, 2-hydroxystilbamidine seems preferable for the initial treatment.

Acknowledgment

The authors take this opportunity to express their gratitude to Dr. Richard J. Browning for his assistance in assembling material for Case 7.

References

1. Gilchrist, T. C.: A Case of Blastomycotic Dermatitis in Man, Bull. Johns Hopkins Hosp. 1:269, 1896.
2. Smith, J. G., Jr., Harris, J. S., Conant, N. F. & Smith, D. T.: An Epidemic of North American Blastomycosis, J.A.M.A. 155:641, 1955.
3. Wilson, J. W., Cawley, E. P., Weidman, F. D. & Gilmer, W. S.: Primary Cutaneous North American Blastomycosis, Arch. Dermat. 71:39, 1955.
4. Schwarz, J. & Baum, G. L.: Blastomycosis, Am. J. Clin. Path. 21:999, 1951.
5. Cherniss, E. I. & Waisbren, B. A.: North American Blastomycosis: A Clinical Study of 40 Cases, Ann. Int. Med. 44:105, 1956.
6. Curtis, A. C. & Bocobo, F. C.: North American Blastomycosis, J. Chronic Dis. 5:404, 1957.
7. Harrell, E. R. & Curtis, A. C.: North American Blastomycosis, Am. J. Med. 27:750, 1959.
8. Smith, D. T.: Immunologic Types of Blastomycosis: Report of 40 Cases, Ann. Int. Med. 31:463, 1949.
9. Sigrest, M. L., Lummus, F. L., Campbell, G. D., Busey, J. F. & Allison, F.: Effect of Diagnostic Skin Testing of Antibody Levels for Histoplasmosis, New England J. Med. 269:390, 1963.
10. Abernathy, R. S. & Jansen, G. T.: Therapy With Amphotericin B in North American Blastomycosis, Ann. Int. Med. 53:1196, 1960.
11. Seabury, J. H. & Dascomb, H. E.: Treatment of Systemic Mycosis, J.A.M.A. 188:509, 1964.
12. Butler, W. T., Bennett, J. E., Alling, D. W., Wertlake, P. T., Utz, J. P. & Hill, G. J.: Nephrotoxicity of Amphotericin B, Ann. Int. Med. 61:175, 1964.
13. Lockwood, W. R., Busey, J. F., Batson, B. E. & Allison, F.: Experiences in the Treatment of North American Blastomycosis With 2-hydroxystilbamidine, Ann. Int. Med. 57:553, 1962.

Distaff Doctors

Several decades ago, about 4 per cent of entering medical students were women. Today the figure is about 8½ per cent. The same ratio appears on graduation day when the M. D. degrees are handed out—about 8½ per cent go to women. However, of all physicians in practice now, only about 6 per cent are women. This is not due to withdrawal of women from practice. It is simply that years ago the ratio was so much lower than 8½ per cent. Some women do withdraw because of marriage, motherhood, or moving with husbands to states where they are not licensed. But attrition for these reasons is not, today, very large. Many women doctors return to practice when their children reach school age.

The situation in the United States in this respect is almost unique. In the rest of the world, the ratio of females in the medical population is far above our 8½ per cent. Next door, in Canada, the figure is 12 per cent. In Great Britain it is 24 per cent. And in Eastern Europe it often exceeds 50 per cent.

According to the Association of American Medical Colleges, women significantly outscore men in some components of the Medical College Admission Test. It is hard to think of any field of medical practice in which women would be disqualified. If males can be successful gynecologists, why can't women be successful urologists? And females have been using needles and thread since childhood, so they ought to be better than men at putting in sutures and doing post-operative closings. There is no reason why females wouldn't make excellent dermatologists, pediatricians, and psychiatrists.

We have in our country an enormous and largely untapped pool of women college graduates. In spite of this we are concerned about the shortage of medical school applicants. Someone ought to suggest more vigorous recruitment of women graduates. They could be a substantial increment to our reservoir of medical practitioners. And decorative, too.—The Journal of the Medical Society of New Jersey.

Metabolic Emergencies Common in the Elderly

Thomas H. McGavack, M. D., and Pierre P. Tulou, M. D.

THE medicine man of the primitive tribe and the skilled physician of the mid-twentieth century share in common the need to face emergencies in an attitude of impeccable calm and self-assurance. Solely upon this depended the success of the medicine man and indeed of the physician of more than fifty years ago. The imperturbability and confidence imparted thereby still are extremely important. In his management of an emergency, however, the physician of today stands on a firm scientific footing not available to those of preceding generations who practiced the healing art. The general practitioner of medicine usually is the first to meet and treat the medical emergency. The dramatic nature of the situation demands (1) a cool head, (2) recognition and understanding of the reactions of people to severe emotional stress, (3) a masterful attitude, (4) skill in attention to "little things" while evaluating history and physical findings and (5) knowledge and use of the scientific tools available for diagnosis and treatment of the emergent problem.

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Control Mechanisms

In metabolic emergencies commonly affecting older persons, potential or actual changes in the most jealously guarded, homeostatically controlled function of the body, that is, the pH of blood and tissue, are primarily involved. The mechanisms controlling the bodily regulation of this function under physiological conditions are four:

(1) Buffer systems of blood, lymph and intracellular fluid.
(2) Rate of carbon dioxide excretion by the lungs.
(3) Excretion of acids and bases in the urine.
(4) Formation of ammonia by the kidney.

These mechanisms are mentioned in the order of speed with which they influence pH, the most rapidly acting being placed first, Numbers 3 and 4 are more or less simultaneously effective. Under physiological conditions, each of the four mechanisms responds in orderly fashion to the predetermined need. As a group, they underlie the exchange of anion in the never ending oxidation-reduction processes by which body metabolism is maintained.

It is not surprising that disturbances primarily affecting any one of these four mechanisms may create an acute or chronic emergency of a severe nature. For instance, in the first group, carbon monoxide poisoning represents a classical example of an acute emergency. In the daily practice of medicine, interference with the rate of carbon dioxide excretion by the lungs is most frequently seen in obstructive emphysema leading to respiratory acidosis which, under certain conditions, may alternate with episodes of respiratory alkalosis. If either of these conditions is prolonged or becomes chronic, secondary compensatory factors are brought into play in which renal function takes a leading role. In many metabolic emergencies, for example, diabetic coma, renal mechanisms are invoked in an effort to control the severely disturbed acid base balance. Primary disease of the kidney, with or without renal failure, may alter such processes.

In clinical medicine, do we have any practical means of appraising the actual status of acid-base balance? Of prime importance to the practitioner, in this connection, are three determinations on arterial blood that can be carried out with reasonable ease in any clinical hospital laboratory: pH, bicarbonate (HCO_3^-) concentration and partial pressure of carbon dioxide (PCO_2^-).

Here, we are not directly concerned with methods. It should be emphasized, however, that satisfactory procedures exist for determination of all three of these parameters of acid-base be-

Submitted to the Publication Committee, September 25, 1964.

havior. Such methods are not without their sources of error and such deviations can be considerable under improper conditions. Perhaps the greatest mistakes are introduced by mishandling of blood before it is analyzed. In any event, one should be sure of his laboratory and its competence before widely employing such studies.

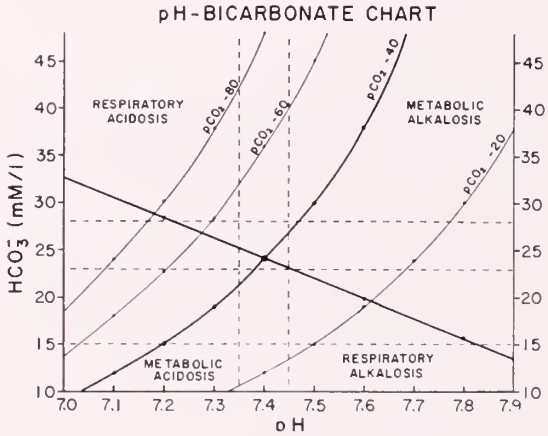

Figure 1

For practical purposes it has been proven possible to determine two of these parameters of acid-base balance and obtain the third by calculation.[1, 2, 3, 4] Usually determined are the pH of blood and its total carbon dioxide content. The bicarbonate value can be calculated from the latter by application of a simple factor. From the pH and bicarbonate figures, the third parameter, that is, the partial pressure or tension of carbon dioxide, can be derived. These three findings are the variables which define the position of a point on the pH-bicarbonate diagram (Figure 1). They vary interdependently according to the Henderson-Hesselbach equation, $pH = 6.10 + \log. \frac{HCO_3^-}{k(PCO_2)}$, where $k = 0.0301$ at sea level. The normal average range for each of these variables is shown by the dotted lines across the face of the chart. It will be noted that under physiological conditions the pH has been known to vary from 7.35 to 7.45; bicarbonate concentration in the plasma from 23 to 28 millimols per liter; and the partial pressure of carbon dioxide in blood from 37 to 46 millimeters of mercury. If two of these three parameters are known, then the third point can be plotted on the diagram. If, however, only one of these has been determined, then the point cannot be ascertained and the true acid-base pattern of the blood cannot be recognized. Note, for instance, in Figure 1 that a bicarbonate value of 15 can be associated, at least theoretically, with a wide range of pH and PCO_2 values. In actual practice it is usual to determine the pH and the total carbon dioxide concentration of true plasma. From the latter figure the bicarbonate concentration can be determined by formula or by simple subtraction of 1 millimol per liter for the dissolved carbon dioxide concentration. The error thus introduced is negligible for purposes of clinical practice.

Know Your Laboratory

As in the case of all laboratory procedures, one should know his laboratory and its normal values, as well as its weaknesses. The determination of pH by present methods is not tedious. It may be termed "tricky," but once the errors which may be easily encountered are fully understood, it can be a very reliable procedure, applicable in the clinical laboratory. The same remarks will apply to many laboratory procedures and certainly to the determination of bicarbonate concentration by any method in use today.

The normal buffer line of true plasma is shown running diagonally across this chart (Figure 1) downward, from left to right. "The buffer value of a solution is the amount of acid which must be added to cause a change of 1 pH unit."[2] The buffer value of true plasma, represented by the slope of this line, may be expressed as $\beta = -(\triangle HCO_3)/(\triangle pH)$, where β=buffer value, $\triangle HCO_3$= change in bicarbonate concentration, and $\triangle pH$=change in pH. This value for true plasma is 21.6 millimols per liter per pH unit, that is, the buffering value decreases with increasing pH. The center of our pH-bicarbonate diagram is in actuality the junction point of the average bicarbonate, the average pH, the buffer line for normal or true plasma, and the line for a 40 mm. of mercury partial pressure of carbon dioxide. When any given point plotted on the diagram is considered in reference to these four factors (pH, bicarbonate, PCO_2 and buffer line values), it is possible to show the type of disturbance which has occurred in acid-base balance. If a disturbance exists in gaseous exchange, it is clear that the partial pressure for carbon dioxide will vary and a corresponding change in the concentration of plasma bicarbonate will ensue. If there is no compensation for such a disturbance then the movement of a point representing the three parameters of acid-base balance will be directly along the buffer line, either above or below the normal PCO_2 line, depending upon whether carbon dioxide is being retained, when the partial pressure will be high, or whether it is being "blown off" by hyperventilation, when the concentrations will be low. In the former instance, we are faced with an example of respiratory acidosis and in the latter, of respiratory alkalosis. From the diagram, it is clear that the former condition will be represented by points

lying within the upper left hand corner, and the latter, by points lying in the lower right hand corner. By the same token, if the respiratory apparatus is normal, it is evident that a pure metabolic disturbance will move along the normal PCO_2 line, i.e., 40 mm. of mercury. Under such conditions, a metabolic acidosis may be represented by any point lying in the lower left hand corner of the field. Values for the pH and the carbon dioxide combining power or plasma bicarbonate are both low.

Total Disturbance Rare

Metabolic alkalosis will be represented by points above the buffer line and to the right of the pH 7.4 line. In practice, a totally uncompensated disturbance of acid-base balance is rarely if ever, observed. Any attempt to disturb the acid-base balance of the body, by whatever means, is immediately met by compensatory mechanisms and, therefore, it will be rare to find respiratory acidosis in which renal factors for adjusting the acid-base balance towards the normal are not present. Cases of mixed metabolic and respiratory acidosis are known, as in emphysema with diabetic acidosis. In the respiratory acidosis of the obstructive type of emphysema, attempts on the part of the body are always made to bring the pH back to normal. Let us consider the application of this chart (Figure 1) to the management of several patients with metabolic emergencies:

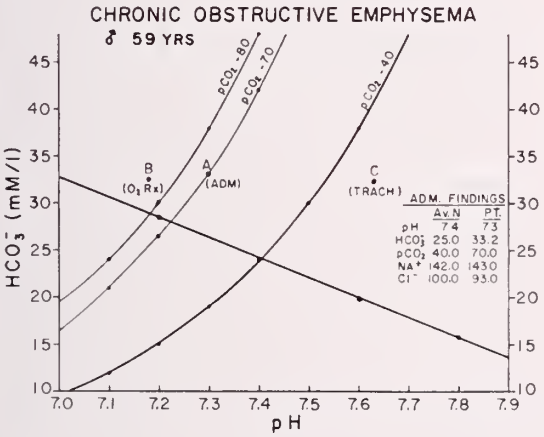

Figure 2

Case 1.—Chronic obstructive emphysema with respiratory acidosis and CO_2 narcosis followed by respiratory alkalosis (Figure 2).

At the time of the present admission, this 59-year-old man, with a history of chronic alcoholism for many years and of obstructive emphysema for not less than 10 years, complained chiefly of coughing. He was deeply cyanotic and markedly dyspneic. The history further led us to believe that we were dealing with a severe respiratory infection during recovery from an alcoholic episode.

At the time of admission, the pH of arterial blood was 7.30, the bicarbonate concentration 33.2 and the PCO_2 70. The point defined by these figures on the chart is above the buffer line and to the left of the normal PCO_2 isobar (Figure 2). It, therefore, represents the presence of respiratory acidosis with a retention of carbon dioxide. Since it is above the buffer line, partial compensation has taken place. Had this not occurred it is clear that the pH without any compensation would have been 7.22 and the bicarbonate concentration 27.7 millimols per liter. If one reads the distance from this point to the buffer line vertically, it will be seen that 6.7 meq./l of fixed acid have been buffered by blood and renal mechanisms. This seems to be well accounted for in the lowering of the serum chloride which was determined to be 93 meq./l.

The patient was placed upon a regimen including bronchodilators, antibiotics, and oxygen by catheter at the rate of 5 to 6 liters per minute. Within five hours he had become semicomatose and even more cyanotic. Repetition of his determinations at this time showed an even more severe acidosis with a pH of 7.18, a bicarbonate value of 32.5 mM/L and a PCO_2 of 85 (point b, Figure 2). This patient was obviously in a condition of carbon dioxide narcosis, with a decreasing pH and an increasing carbon dioxide retention in the blood.

It may be pointed out here that had the carbon dioxide combining power or, that is, plasma bicarbonate, been the only laboratory test made for determining the condition of the patient, we would have assumed that little or no change had taken place, as the bicarbonate on admission was 33.2 millimols per liter and at the time of coma 32.5 millimols per liter. In actuality, we can see that whatever therapeutic help had been derived from our bronchodilators and our antibiotics was more than offset by the damage done by a high intake of oxygen, in a patient whose respiratory center was already insensitive to the high carbon dioxide level present. At this point tracheostomy was performed, the airways were sucked clear of thick, tenacious, bronchial secretions and air was introduced by way of the Bennett intermittent positive pressure apparatus. Consciousness was regained rapidly and the next day asymptomatic alkalosis was present with the pH at 7.63, the PCO_2 at 33 and the bicarbonate at 32.3. It can be seen from the chart that there was now an excess of alkali in the amount of 13.7 millimols per liter.

Had the CO_2 combining power or the serum bicarbonate alone been determined in this patient, none of the drastic changes taking place in the pH and PCO_2 would have been uncovered.

It may be well to comment on the occurrence of alkalosis in chronic obstructive pulmonary emphysema, a finding which occurred in Case 1 only after hypercapnia had been relieved. Robin[3] has recorded alkalosis in 21 of 156 patients through 40 determinations from a total of 340 observations while carbon dioxide tensions were still elevated, that is, while hypercapnia still existed. In the alkalosis which appears when hypercapnia is relieved rapidly, as in Case 1, mobilization and excretion of carbon dioxide via the lung occurs more quickly than bicarbonate can be excreted by the kidney. In this patient the alkalosis disappeared without incident or symptom.

Development of alkalosis in instances of chronic hypercapnia is a matter which becomes of increasing importance in relation to diuretic therapy, particularly with the chlorothiazides. Hypochloremia and chloride depletion which may attend the use of these agents may also retard the return of bicarbonate to normal values, even after a proper airway has been established. In 14 of 32 individuals, that is, in 44 per cent, Robin found moderate to severe chloride depletion with serum chloride levels below 94 meq. 1; in 5 of these individuals, the values ranged from 75 to 89 meq./1.[3] The hydrogenated thiazides are more likely to produce this situation than are the nonhydrogenated thiazides.[5] Chlorothiazide is a characteristic example of the nonhydrogenated thiazides, and hydrochlorothiazide is an example of the hydrogenated group. Of course, adrenosteroids of the 11-oxycorticoid type also must be considered suspect, as these show a tendency to produce a hypernatremic, hypokalemic, hypochloremic type of alkalosis. If chloride ions are made available in numbers sufficient to produce a drop in plasma bicarbonate levels, once the hypercapnia is relieved, this alkalosis may be avoided.

Therapeutic agents which influence a shift of hydrogen ions from extracellular to intracellular water or which enhance the renal excretion of hydrogen ions, favor the development of alkalosis in the presence of hypercapnia. Among such agents are mercurial diuretics, the chlorothiazides and the 11-oxycorticoids. In addition to the hypochloremia which may attend the use of one of these agents, there is always the danger of serious whole body potassium depletion, a depletion which is not always easy to recognize from the serum potassuim levels.

Case 1 illustrates well the major problems to be found in acute respiratory failure. The treatment of this emergency (Table 1) will obviously vary with the general condition of the patient and is really predicated upon mental status and the complications produced by the underlying disease. The immediate aim of treatment is establishment and maintenance of an open and clean airway with the development of adequate alveolar ventilation. Since these statements apply to any type of acute respiratory failure, they are applicable to respiratory acidosis secondary to underlying bronchitis and emphysema or to other types of fibrosing pulmonary lesions. When we treat respiratory acidosis, the following should be instituted, as indicated:

Table 1

Treatment of Severe Respiratory Acidosis With or Without CO_2 Narcosis

Metabolic Fault—retained CO_2; diminished pH as a result of airway obstruction.

Major Compensatory Mechanism—Renal excretion of acid.

Therapy:

1. Preventive
   - (a) Note early signs—sudden change in cough, cyanosis, dyspnoea.
   - (b) Avoid respiratory depressants—barbiturates, opiates.
   - (c) Avoid oxygen in high concentration.
   - (d) Avoid combinations of (b) and (c).
   - (e) Treat even minor infections vigorously.
2. Active—Decrease or relieve obstruction.
   - (a) Bronchodilators—isoproterenol, vaponefrin, aminophylline.
   - (b) Aerosols—detergents, enzymes, fibrinolysins.
   - (c) Control infection.
   - (d) Anti-inflammatory steroids.
   - (e) Oxygen slowly, or with pressure apparatus.
   - (f) Tracheostomy

(1) *Sedation and Anti-Sedation.*—The sedatives used in acute respiratory acidosis should be those with no influence upon lower respiratory centers. If there is an asthmatic background, antihistamine drugs may play an important role, particularly those such as benadryl that exert a hyoscine-like action on the cerebral cortex. All too commonly the patient is seen after he has received harmful sedatives. Reference here is made to barbiturates and to opiates. If the patient is not critically ill, it is best to allow the effects of these drugs to "wear off." When, however, untoward effects are severe in the case of barbiturate overdosage, vanillic diethylamide (Emivan-USVC) by mouth or intravenously helps the respiratory depression associated with carbon dioxide accumulation. In the same general group of substances is bemegride (Megimide-Abbott) which can be used intravenously to counteract barbiturate poison-

ing. Other respiratory stimulants such as caffeine, nikethamide and aminophyllin may be employed.

In the case of opiates, probably the best single antidote is nalorphine hydrochloride (Nallinе-MSD). Five to 10 mg. intravenously is the average amount, but as much as 40 mg. can be given in a single dose if administered slowly. Levallorphan tartrate (Lorphan tartrate-Roche) also is useful in this connection. It acts quickly (1 minute) and the effect lasts for from 2 to 5 hours. As a rule 1 mg. intravenously will be all that is required. Additional doses of half that amount, however, may be given.

(2) *Infections.*—These should be brought under control as promptly as possible with the use of antibiotics to which predominant organisms have proven sensitive. The usage of such materials in aerosols has not been too encouraging.

(3) *Congestive heart failure.*—Where this occurs in respiratory acidosis, treatment with digitalis, diuretics and salt restriction should be employed. However, should there be any tendency to lapse into coma, and a high PCO_2 with very low pH exists, salt restriction should be carried out with caution.

(4) *Bronchodilators.*—Isoproterenol (Isuprel) and aminophyllin probably are the two best. If status asthmaticus exists, particularly in the presence of infection, it may be necessary also to employ either adrenosteroids or ACTH, both of which may favorably influence the bronchospasm as well as the inflammatory reaction. Of the anticholinergic agents, methscopolamine bromide (Pamine-Upjohn) is of some value and can be given in doses ranging from 1.25 to 5 mg. three or four times daily.

(5) *Aerosols, Other than Isuprel.*—In an effort "to thin" tenacious bronchial secretions, various detergents and enzymes have been used. None of these has been too successful. Of the detergent aerosols, Alevaire (Winthrop) has been the most satisfactory. This contains 0.125 per cent superinone with 2 per cent sodium bicarbonate and 5 per cent glycerin. In the seriously ill, 500 ml. may be used by continuous nebulization for from 12 to 24 hours whereas in the less acutely ill, this material may be employed for ½ to 1½ hours daily, or 3 or 4 times daily. Of the lysing enzymes, Dornavac (MSD) which contains 100,000 units of lyophilized pancreatic dornase per vial in 2 cc. of diluent can be used 1 to 3 times daily for 2 to 6 days. Streptokinase systemically is worthy of trial. This may be taken orally or buccally. With oral administration, the dosage should be large, corresponding to 50,000 units of streptokinase per dose; this will represent 4 or 5 tablets of the usually available preparations.

(6) *Inspired Gases and Respirators.*—When intermitten positive pressure breathing is used, probably compressed air is preferred to oxygen as it reduces the risk of apnea. High oxygen mixtures, however, can be employed by automatic positive pressure and tank respirators. One should be sure that an effective humidifier is present, as oxygen is dry when delivered from the tank. If the patient tends to be apneic, then it is best to use oxygen in an apparatus that ventilates automatically. Barach employs intermittent positive pressure breathing with exsufflation taking place under negative pressure. He uses a positive pressure up to 40 mm. of mercury but starts the negative phase quickly and cycles it so that the duration of the expiratory phase is 0.02 seconds, as compared with 1 second or more with the ordinary intermittent positive pressure breathing machines. He is meticulous in controlling the length of all phases and the pressures used. In the apparatus he employs the inspiratory phase should last not more than 2 seconds with a pressure of 40 mm. of mercury followed by expiratory phase with an equally high negative pressure as described. His theory is that the very high positive pressure during inspiration insures a wide opening of the bronchial tree and the smaller passages leading to the alveoli, while the marked negative pressure exerted during expiration is sufficient to cause a sucking out of secretions from the bronchi and thereby aids the effectiveness of coughing as well as a free flow of secretions.

Where possible, we believe it is best to introduce oxygen by nasal catheter, beginning with a flow of 1 l./min. and gradually increasing. Intermittent positive pressure breathing has, in our hands, always decreased the cardiac output, even in normal individuals and at a pressure of only 12 cm. of water.[6] Nevertheless, it can be useful when carefully applied, either with or without tracheostomy.

Segal and Attinger[7] believe that oxygen therapy often can be given in the "iceless" refrigeration tent, in which oxygen concentrations up to 40 per cent can be readily obtained. A simple ABC plastic face tent is less expensive and can give oxygen concentrations up to 50 per cent when the oxygen flow rates are 6 liters per minute. In such tents patients usually do not complain of claustrophobia nor of a sense of suffocation. These workers also believe that the danger of inducing carbon dioxide intoxication in respiratory acidosis has been overemphasized. When this is

present, however, they advise a nasal catheter-humidification type of technique. Here, they start with air or low concentrations of oxygen and gradually increase until 30 per cent oxygen is being delivered at flow rates of 4 liters per minute or under. These authors are presently employing a multi-purpose-air-pressure-breathing unit. This is called Vent-EL-Aire, which is manufactured by the Elliott Medical Plastics Company, Inc., of Lynn, Massachusetts. They find that this machine can combine 4 therapeutic functions:

"(1) IPPB I—Intermittent positive pressure breathing during inspiration.

"(2) EWNP—Exsufflation with a rapid negative pressure (cough).

"(3) Resuscitation—By means of alternating positive pressure on inspiration with passive or negative pressure on expiration.

"(4) Therapeutic aerosols—Independent supply of therapeutic aerosols during inspiration only."

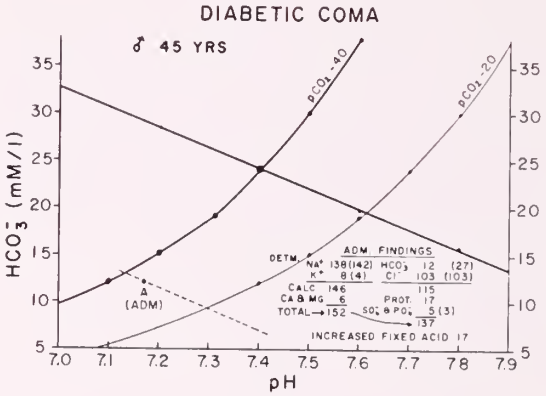

Figure 3

Case 2.—Diabetic Coma (Figure 3). In this patient is illustrated what probably is the most common medical emergency associated with metabolic acidosis, namely, diabetic coma. Just as Case 1 is not a pure or totally uncompensated respiratory acidosis, so the patient we are about to describe is not a pure or totally uncompensated case of metabolic acidosis. Whenever the pH of the body is threatened, compensatory mechanisms always come into play, irrespective of the primary disturbance.

This is a 45-year-old male, known to have had diabetes for six years, which had been controlled with 20 units of Lente insulin daily plus reasonable dietetic care. Shortly prior to admission, an upper respiratory infection with generalized aching, weakness and fever had developed. Since his eating was irregular, he had discontinued most, if not all, of his doses of insulin and on the fifth day of his infection became drowsy,

Table 2

Values of Normal Acid Base Constituents of Plasma Compared With Those of Moderately Severe Diabetic Coma (Meq./L)

Base		Acid		
	Normal			Coma
Na	142(138)	CO_2	27	12
K	4(8)	Cl	103	103
~~Ca~~	~~4~~	~~PO_4~~	~~2~~	3
~~Mag~~	~~2~~	SO_4	1	2
		Prot	17	17
		~~Org.Ac.~~	~~2~~	16
Totals	152		152	152

Calculated

sleepy and, finally, semicomatose four hours prior to admission. At the time of admission, his arterial pH was calculated to be 7.17, his plasma bicarbonate 12.0 millimols per liter, and his partial pressure of carbon dioxide 35.2 mm. of mercury. When the point determined by these three variables is plotted on the pH-bicarbonate diagram it will be seen to be definitely in the area of metabolic acidosis, lying left of the pH 7.4 line, to the right of the normal carbon dioxide tension line and well below the normal buffer line, in the lower left hand corner of the chart.

When diabetic coma occurs in a patient otherwise not suffering from some disease which may tend to alter acid-base balance, it is possible to gain a fair picture of the severity of the condition without resort to a pH or PCO_2 determination. In this instance, we depend upon four determinations in the serum. If one charts the normal constituents of the plasma in relation to the balancing of anions against cations, it may be noted from Table 2 that there are 152 meq. of base or anions balanced against 152 meq. of acid or cations. In acute acidosis, such as develops in diabetic coma, fixed base, particularly sodium and potassium, are drawn upon freely, as they are quickly mobilized. The body supply, however, is limited, particularly in the case of sodium. Since a major part of the potassium supply is intricately bound intracellularly, its removal may be attended by considerable alterations in cellular metabolism. On the other hand, while calcium and magnesium also may be mobilized to supply base, the bodily stores of these materials are quite flexible. The large bony reservoir of calcium is available. Therefore, serum values neither for calcium nor magnesium change much in the acute acidotic state and need not be calculated. On the acid side of the picture, the two

major anions are the CO_2 radicle and chlorine. Both of these are relatively labile. Protein makes up a rather constant 17 meq. of potential cationic radicles. In disturbances of acid-base balance of a metabolic nature, phosphate and sulphate both rise but the rise is negligible in relation to the overall alterations in total fixed acids. Therefore, these three determinations do not need to be made in order to make a reasonable determination of the alkali deficit which exists in any given degree of diabetic coma. This deficit occurs as a result of the accumulation in the system of organic acids, particularly betahydroxybutyric and diacetic acids and acetone.

It is clear from the calculations in Table 1 that the alkali deficit, or the excess of fixed acid in the blood, can be calculated with reasonable accuracy from the serum sodium, potassium, carbon dioxide and chloride determinations. In the present instance, such a calculation showed an excess of approximately 16 to 17 millimols of fixed acid, a figure almost identical with that derived from utilizing our pH bicarbonate chart and determining the excess of fixed acid by the vertical distance between the point defined by the pH-bicarbonate values and the buffer line. Were this point on the PCO_2 40 line the case would be one of pure uncompensated metabolic acidosis. It lies to the right and below the line, however, and therefore represents a partially compensated metabolic acidosis, even though the compensation is slight. It goes without saying that this patient responded promptly to the judicious use of insulin, water, minerals and food.

Case 3.—Obstructive Pulmonary Emphysema with Diabetic Acidosis (Figure 4). Unfortunately, in older persons, we rarely find a single uncomplicated disease or uncomplicated medical emergency. In Case 3 we have a patient with obstructive pulmonary emphysema and diabetes mellitus who, in the course of a rather severe chronic respiratory acidosis, developed diabetic coma (Figure 4).

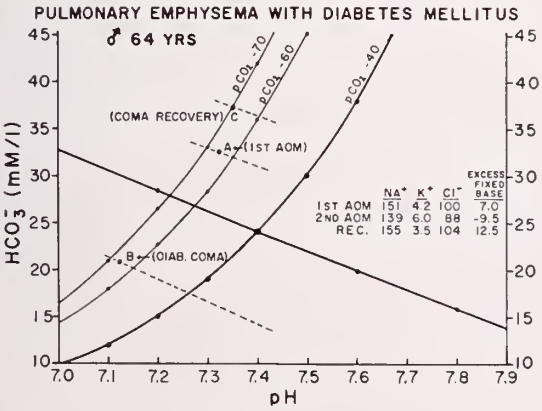

Figure 4

This 64-year-old man was first admitted to the hospital with a long standing history of chronic obstructive pulmonary emphysema and diabetes mellitus of at least 8 years' duration, which required for its control moderate dietary restrictions and 10 units of Lente insulin daily. Alterations in his acid-base pattern are shown in Figure 4. It will be seen that his plasma pH was 7.32 with a bicarbonate of 32.5 millimols per liter and a PCO_2 of 65 mm. of mercury. By location of this point on the chart it is clear that he was suffering from a partially compensated respiratory acidosis. His diabetes was found to be, at this time, under reasonably good control. Had his respiratory acidosis been totally uncompensated, it is clear that his pH would have been 7.24 and the bicarbonate 27.0 millimols per liter. The compensation for his chronic respiratory acidosis amounted to approximately 6.0 millimols per liter of fixed base, as can be read from the vertical distance upward from the buffer line to the point plotted on the pH-bicarbonate chart.

At the time of his second admission to the hospital, approximately 6 months after the first, he was semicomatose with all the confirmatory signs of obstructive emphysema. Both sugar and acetone, however, were present in the urine. The acid-base findings on admission are shown in relation to point B of Figure 4. It can be seen that the pH was 7.2, with the bicarbonate low at 20.8 millimols per liter and the carbon dioxide retention high at 65 mm. of mercury. If a venous blood CO_2 combining power alone had been depended upon to indicate a change in acid-base balance, the severity of the superimposed diabetic coma might have been overlooked. If an underlying respiratory acidosis in this case had not existed, the diabetic coma would have been associated with a pH of 7.26 and a bicarbonate value 17.2. The underlying respiratory acidosis lowered the pH considerably and at the same time helped to raise the bicarbonate slightly. Fixed acid in the blood increased to between 16 and 17 millimols per liter.

As the diabetes was brought under control, his chronic obstructive pulmonary emphysema returned to *status quo ante*, with a pH at 7.35, the bicarbonate 37.5 millimols per liter and the PCO_2 70 mm. of mercury (Point C). If anything, the respiratory acidosis was slightly more severe than before the diabetic coma but it was also better compensated. Had it been totally uncompensated after the episode of diabetic coma, the pH would have been 7.22 with a bicarbonate of 27.8. It may be added here that under continued treatment for the emphysema aeration slowly improved.

In looking at the serum electrolyte pattern of this subject (Figure 4), it is clear that at the time of his first admission, his respiratory acidosis was reasonably well compensated with an excess of fixed base (7 millimols per liter) and a chloride within normal range. During the diabetic coma there was an excess of fixed acid due to the formation of large amounts of organic acids. Upon control of this condition, however, the electrolyte pattern went back to its former status, representing a part of the picture of the compensated respiratory acidosis present.

In handling this type of patient it must be realized that one acidotic state is superimposed upon another. It may be thought that the diabetic coma in this instance would have given an added stimulus to the respiratory center and thereby enabled the body to blow off CO_2 to better advantage. As is well known, this was not the case. Once the respiratory center is dulled to the stimulus of an acid pH or to the stimulus of carbon dioxide, it no longer can be further stimulated by increasing the concentration of CO_2. Therefore, one of the characteristic clinical guides for the recognition of diabetic coma, namely, Kussmaul breathing, was not present in our patient. Unless the pH is very low, the condition should be handled just as one would treat a respiratory acidosis plus the usual care for diabetic coma. If, however, the pH is exceptionally low, or if the calculated figure for bicarbonate is 10 millimols per liter or less, then fixed alkali should be administered. We prefer M/6 sodium lactate. Such a procedure may be life-saving. It is done with the full realization that a compensatory, sometimes severe, alkalosis will occur when the diabetic state comes under control. In most instances, however, the alkalosis we have seen following such procedures has been asymptomatic. It disappears as the electrolyte balance of the body is fully restored following recovery from the diabetic coma.

From the work of Robin[3] and others the administration of both sodium and chloride can be useful in preventing respiratory carbon dioxide narcosis, a serious condition in the best of circumstances. We feel that it is best, however, when needed in diabetic coma, to give "unbuffered" alkali as above noted. In the presence of chronic pulmonary emphysema any signs of carbon dioxide narcosis should be watched for as the patient recovers. In such instances, the use of sodium lactate may be followed later by the use of sodium chloride.

Case 4.—Asthma: Chronic Obstructive Pulmonary Emphysema with Cor Pulmonale (Figure 5). A 58-year-old white male who had had a

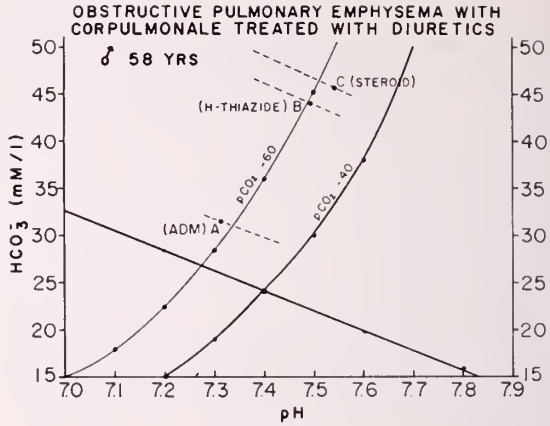

Figure 5

history of asthma for approximately 40 years and whose emphysematous condition had been recognized for at least 15 years showed, on admisson, a fixed barrel type of chest, with coarse rhonchi throughout both lungs and a very few high pitched musical rales. He had been subject to episodes of congestive failure for the preceding five years and had shown attacks suggestive of acute pulmonary edema during the year prior to admission. Immediately prior to admission he had been treated mainly with bronchodilators and antibiotics. On admission, he was slowly digitalized and was given mercaptomerin sodium (thiomerin) 2 cc. every other day for 5 doses.

At the time of admission, he was in respiratory acidosis with a pH of 7.31, plasma bicarbonate 31.6, and carbon dioxide tension of 65 mm. of mercury (Figure 5). Hydrochlorothiazide 50 mg. daily also was prescribed and several antibiotics were tried. Ten days later reasonable compensation had been achieved. At this time, his acid-base balance showed a pH of 7.49, plasma bicarbonate 44.0, and carbon dioxide tension of 60 mm. of mercury. Despite his high carbon dioxide tension, mild alkalosis existed. An anti-inflammatory steroid was added to the regimen; this afforded additional symptomatic relief of the cardiopulmonary condition, but altered acid-base balance further towards the alkaline side with frank alkalosis present—pH 7.54, plasma bicarbonate 45.7 and carbon dioxide tension 55. The excess of fixed base rose during treatment from 6 millimols per liter on admission to 22.0 and later to 24 millimols per liter. During the period of alkalosis, however, this individual was free from cardiac manifestations of his pulmonary disease and felt better than he had prior to the steroid therapy.

In cases of this type, one must steer a therapeutic course (Table 3) between Scylla and Charybdis with full recognition of the fact that the hydrogenated thiazides and adrenosteroids,

either or both, may produce an undesirable alkalosis. Fortunately, in this individual, the alkalosis was without any symptoms whatsoever and the patient was able slowly to reduce his usage of both of these groups of drugs. A frank tetany is not common in the alkalosis of respiratory type but we have seen the rapid restoration or normal carbon dioxide tensions associated with rather severe neurologic manifestations, including tetanic convulsions or diffuse muscle twitchings, other altered neurological signs and a comatose state. Robin[3] believes these manifestations can be considered a "possible consequence of disorderly cerebral metabolism related to brain intracellular alkalosis."

Table 3

Cor Pulmonale With Failure

Metabolic Fault—Fluid, electrolyte and CO_2 retention; diminished pH.

Major Compensatory Mechanism—Renal adjustment of pH; effort to improve pH and retain K.

Therapy:

1. All therapy as for "uncomplicated" respiratory acidosis.
2. Digitalis—if R.heart failure is present.
3. Mercurial and thiazide diuretics. Add potassium to the regimen.
4. Extra caution in use of adrenosteroids.
5. If narcosis threatens, add NaCl to the regimen; aldactone (?).
6. If renal failure complicates, improve glomerular filtration—theophyllin derivatives.

The intimate functional and anatomical associations of the lungs and heart make it not surprising to find pulmonary disease secondary to cardiac disturbances and vice versa. Indeed, there are those who believe that any pulmonary disease sooner or later must be associated with some disturbance of cardiac function. Dack[8] has very fruitfully divided patients with pulmonary disease and insufficiency into 5 general groups or categories.

Irrespective of how it is brought about, cor pulmonale always respresents a serious complication of pulmonary disease and requires some variation of therapeutic procedure. It is not always easy to recognize this complication. A sudden increase in the intensity of the common manifestations of pulmonary emphysema may usher in right heart strain. This may be a sudden increase in cough, cyanosis or dyspnea. Orthopnea may take the place of dyspnea, which was previously better from lying down. Other signs of pulmonary emphysema may be aggravated. Whenever they occur, the following are rather diagnostic: (1) engorged neck veins, (2) enlarged and tender liver, (3) generalized edema and (4) increased venous pressure.

On ausculation of the heart there may be an accentuated second pulmonic sound with a systolic murmur. A positive hepatojugular reflux may be elicited by pressure over the right upper part of the abdomen before there is any actual enlargement of the liver. A change in circulation time may be observed but this is not as reliable a sign as an increase in venous pressure. Sometimes the diagnosis is made by x-ray and at other times by the electrocardiographic tracing. In any event, the onset of cor pulmonale with right sided heart failure represents an emergency which must always be expected in the patient with severe obstructive pulmonary emphysema. Moreover, the resulting emergencies may occur not only as a result of the complicating cardiac condition but also as a sequence of therapy aimed at improving the cardiac function.

In conclusion, it is important to realize that no single test for acute emergent disturbances in acid-base balance can be useful in all situations.

For a complete picture of the disturbance which exists we believe it is necessary to know the blood pH, the bicarbonate concentration and the serum sodium, potassium and chloride levels as well as the blood urea nitrogen and nonprotein nitrogen.

From a study of the results of these determinations, it is our feeling that the derangement in acid-base balance can be fully categorized and its association with disease of pulmonary, cardiac or renal origin well appraised when considered in conjunction with specific tests applicable to the individual disease.

Logically applied, the results of the above tests will lead to adequate and useful therapy. When repeated at proper intervals, they will, moreover, enable the physician to avoid many iatrogenic problems of an acute nature.

References

1. Singer, R. B. & Hastings, A. B.: Improved Clinical Method for Estimation of Disturbances of Acid Base Balance of Human Blood, Medicine 27:223, 1948.
2. Davenport, H. W.: ABC of Acid Base Chemistry, Univ. Chicago Press, ed. 4, 1961, p. 48.
3. Robin, E. B.: Abnormalities of Acid Base Regulation in Chronic Pulmonary Disease With Special Reference to Hypercapnia and Extracellular Alkalosis, New England J. Med. 268:917, 1963.
4. Schwartz, W. B. & Relman, A. S.: Critique of Parameters Used in Evaluation of Acid Base Disorders, New England J. Med. 268:1382, 1963.
5. Fuchs, M., Moyer, J. H. & Newman, B. E.: Human Clinical Pharmacology of the Newer Diuretics: Benzothiadiazine and Phthalimidine, Ann. New York Acad. Sc. 88:795, 1960.
6. Tulou. P. & Bromberger, B. B.: Unpublished data.
7. Segal, M. S. & Attinger, E.: Inhalational Therapy, in Naclerio, E. A.: Bronchopulmonary Diseases, Hoeber-Harper, 1957, ed. 1, p. 893.
8. Dack, S.: Clinical Differentiation Between Pulmonary and Cardiac Disease, in Naclerio, E. A.: Bronchopulmonary Disease, Hoeber-Harper, 1957, ed. 1, p. 173.

Cooperative Agreement Between West Virginia University School of Medicine and The Medical College of Virginia*

Edward J. Van Liere, M. D.

Although the School of Medicine of West Virginia University was not formally organized as a two-year school until 1912, the first two years of the medical curriculum have been offered since 1902. Until 1960, students had to transfer to a four-year school upon completion of the first two years of medicine.

The transfer of students at the end of their second year is an important problem with a two-year school. This will be dealt with more fully later; presently, it suffices to state that in the mid-nineteen thirties the transfer of students became in some respects a difficult matter. Some found it hard to gain admission into a four-year school, and, indeed, two students who had completed the first two years never were able to finish their medical education. A certain amount of unrest developed in the student body, especially among those who did not rank high scholastically. The administration had reason to believe that some desirable students were reluctant to enroll in a two-year school because of the possible difficulty of transfer.

An obvious solution to the problem was to work out a plan with some four-year school so that the students would not have to worry about transfer.† The administrators of several four-year schools which were near Morgantown were approached as to the possibility of developing some scheme whereby a certain number of students could be transferred each year.

The Medical College of Virginia (Richmond) was seriously considered at the very beginning as a likely school with which to make such an agreement. For a long time there had been close academic ties with this institution, and throughout the years many students had transferred there. One year, when the West Virginia School of Medicine had a rather large enrollment, 14 students out of one class transferred at the end of their sophomore year. Furthermore, many practicing physicians in West Virginia are graduates of the Medical College of Virginia.

The Author

- **Edward J. Van Liere, M. D., Dean Emeritus and Professor of Physiology, West Virginia University School of Medicine, Morgantown.**

Cooperative Agreement With the Medical College of Virginia

The Dean of West Virginia University School of Medicine had a number of conferences with Dr. William T. Sanger, then President of the Medical College of Virginia, and several members of his administrative staff. On one occasion the Dean was accompanied by the President of West Virginia University, Dr. Charles E. Lawall. The authorities of the Medical College of Virginia were keenly interested in working out an arrangement so that students from West Virginia University could be transferred, and a mutually satisfactory agreement was amiably reached between the two schools.

In essence, the cooperative agreement provided that as many as 20 students, who were bona fide residents of West Virginia and who had completed the first two years of medicine could, on the recommendation of the dean and the faculty of the school, transfer to the Medical College of Virginia to complete their education. In 1950, a new contract was drawn up so that 25 students could have this privilege.

No mention was made in the contract of the scholastic ranking or the sex of the student. The entire responsibility for recommendation for transfer was vested in the Dean and the faculty of the West Virginia University School of Medicine. It was stipulated in the contract that the diplomas would be signed by representatives of both schools.

In 1942, an enabling act was passed by the West Virginia Legislature which provided funds

*Reprinted with permission from the Journal of Medical Education, November, 1964.

†The School of Medicine of West Virginia University had an affiliation with the College of Physicians and Surgeons of Baltimore (now the University of Maryland School of Medicine) from 1902-1912. West Virginia students paid the same tuition as did other students and no other finances were involved. A joint diploma was issued. It is not clear why the affiliation was discontinued.

so the agreement could be put into effect. This cooperative agreement was maintained from 1942 to 1962, a period of 20 years.

The money allotted for the agreement was a direct appropriation to West Virginia University by the State Legislature and was earmarked solely for that purpose. Any surplus at the end of the fiscal year reverted to the general fund of the State. Little money was returned, however, because with the exception of two years (Table 1), most of it was used to fulfill the contract.

There was always a cordial relationship between the two schools. The Dean of the West Virginia University School of Medicine participated in pre-graduation activities and attended each graduation exercise, where he was introduced from the platform.

Financial Arrangements With the Medical College of Virginia

According to the contract signed in 1942, the State of West Virginia paid $1,000 per school year for each student transferred to the Medical College of Virginia. This figure was suggested by President Sanger and his administrative staff and was accepted by the administrators of West Virginia University. The figure seemed qute fair and probably did not represent the actual cost of instruction. Since as many as 20 students could transfer to the third-year class, and an equal number of the fourth-year class, the budget maximum amounted to $40,000 each year, except for the first year in which the contract was in force.

In 1950, when the contract was rewritten so that 25 students could transfer each year, the fee, by mutual agreement, was raised to $1,250 per year for each student. The increase seemed justifiable and probably still did not represent the true cost of instruction. This increased the budget to $62,500 per year.

To lend budgetary stability to the Medical College of Virginia, the original contract stipulated that a minimum of $17,000 be paid for any one class regardless of the number of transfers. In the 1950 contract the minimal guarantee was $23,000. The transfer students were required to pay the same tuition as did the residents of the State of Virginia.

Number of Students Transferred

The number of students who transferred each year may be seen in Table 1.

The yearly average of students transferring was 18.7. The total number of students transferred was 336, and of this number 334 were graduated.

During the years the contract was in force, the sophomore class of the School of Medicine contained approximately 31 students. After the contract was rewritten in 1950 whereby 25 students could transfer, only about six students had to seek places in some other school. The transfer of these six students offered no problem, for there were always several in each class who wished to complete their medical education in a large metropolitan area. As indicated in Table 1 only twice, in 1947 and 1951, did the full quota transfer to the Medical College of Virginia.

Table 1

Students Transferring Under Cooperative Agreement

Year*	No. of Students
June, 1942†	19
March, 1943†	17
December, 1943†	15
September, 1944†	15
September, 1945	8
September, 1946	19
September, 1947	20
September, 1948	18
September, 1949	19
September, 1950	23
September, 1951	25
September, 1952	24
September, 1953	21
September, 1954	18
September, 1955	17
September, 1956	24
September, 1957	21
September, 1958	13

*Year of entry to West Virginia University School of Medicine.

†World War II (1941-1945).

The last group which transferred to the Medical College of Virginia consisted of only 13 students.* These students had entered West Virginia University School of Medicine in September, 1958, and transferred to the Medical College of Virginia in September, 1960. The reason for the small number was that West Virginia University planned to graduate its first class in June, 1962.

Early in 1959, the Dean of the School of Medicine recommended to the governing board of the University that the first graduating class consist of not more than 20 students, preferably less. Actually, the junior class had only 16 students; several of the students who did not transfer to the Medical College of Virginia went elsewhere. A small class seemed desirable since the University Hospital could not be opened until August, 1960, and, further, the outpatient department had not as yet been developed.

Problem of Transfer of Students in a Two-Year School

Since it has been reported that several two-year schools are in the process of development,

*Early in 1960 a new contract was made with the Medical College of Virginia to the effect that no more than 15 students could be transferred.

it seems apropos to discuss briefly the problems of transfer of students. The author is reasonably familiar with problems confronting two-year schools since he took his first two years of medicine at the University of Wisconsin, then a two-year school. Following graduation from medical school, he taught one year at the State University of South Dakota School of Medicine (also a two-year school), and then at the West Virginia University School of Medicine (a two-year school until 1960).

The matter of transfer of students may be a vexing one for the dean of the school. The principal difficulty lies in the fact that while many four-year schools readily accept students who rank scholastically in the upper and even in the middle third of their class, some are reluctant to admit students in the lower third. Unfortunately, there is always a lower third.

One well-known dean suggested to the author that he not distinguish between the upper, middle, and the lower third; the difficulty about this helpful suggestion is that administrators of many schools inquire closely about the scholastic rating of the applicant. In all fairness, in the author's experience there were a few administrators who were willing to accept a student who did rank in the lower third of his class. Nearly all of these students did reasonably well in their clinical years.

Students who do rank scholastically in the lower third of their class are likely to worry about the possibility of not being able to complete their medical course. This undoubtedly causes considerable psychic trauma, and perhaps among the very students who can tolerate it least. Occasionally, students in the second- or third-year class in a four-year medical school may also fail. The circumstances are, however, not exactly comparable.

It is quite possible, furthermore, that some students are reluctant to enroll in a two-year school for fear they might find it difficult to transfer. The picture may have changed somewhat the past few years. However, if new two-year schools are established, the matter of transfer of students should be thoroughly recognized.

Financial Obligations of States to Medical Education

Medical education is costly, and it is often difficult for various reasons, mostly financial, for a state to develop a four-year medical curriculum. At this writing, 11 states do not have a medical school within their boundaries, and 17 states do not support a public medical school.

The citizens of every state should be willing to share the financial burden of training medical students. Certainly no sovereign state should expect other states to do it for them. Moreover, all citizens are anxious to avail themselves of advances made in medical research, and they should willingly pay their share toward obtaining these advantages by supporting medical education and research.

It is obvious from the data set forth in this essay that during the years the contract with the Medical College of Virginia was in force, the citizens of West Virginia paid many thousands of dollars to educate the medical students of their State. It is noteworthy to mention that West Virginia is not a wealthy state.

Since the development of a medical school is such an expensive undertaking, in some instances it might be feasible to establish a two-year medical school. As the economic status of the state improves, such a school eventually might serve as as basis for the expansion to a four-year curriculum.

Some sparsely populated states may find it difficult to establish even a two-year school. In this event the possibility of a regional medical educational program should be thoroughly explored. This could take one of several forms, such as a state working out some cooperative agreement with a four-year medical school, or even of two or three states pooling their resources to establish a medical center in some rather centrally located area.

The above suggestions are not intended to be exhaustive, but to illustrate that various solutions are possible. Local conditions may well suggest other plans after fertile minds have objectively assessed the situation.

Summary

The cooperative agreement between the School of Medicine of West Virginia University and the Medical College of Virginia, which was in force approximately 20 years, worked extremely well. It was a distinctly worthwhile experiment, not only in medical education, but in regional education as well. Considerable national interest was manifested in the arrangement between the two schools, and many inquiries were received concerning it. The cooperative agreement could perhaps serve, in a measure, as a prototype for other institutions which might be interested in working out some form of regional education.

HB 662—Provision for Medical Corporations

THE 57th Legislature in 1965 amended Chapter 30 of the Code to permit the Medical Licensing Board of West Virginia to issue certificates of authorization, enabling corporations to practice medicine and surgery.

Prior to this year, physicians in West Virginia could form ordinary business corporations under Chapter 31 of the Code, but these corporations could not be used to practice medicine. By passing HB 662 (sponsored by Dels. J. Douglas Ayers of Parkersburg and John L. Seabright of Wheeling) the Legislature revoked this restriction, and now corporations formed under Chapter 31 can be used for medical practice, provided that all shareholders are duly licensed physicians and that all medical and surgical practice is carried out through duly licensed physicians.

Advantages of Corporate Practice

The primary advantages of corporate practice are business in nature. The so-called "tax advantages" which have been stressed in articles in publications such as *Medical Economics* are incidental considerations, and by themselves are not usually worth the additional time and expense involved in operating a corporation. The business advantages are as follows:

1. Incorporating makes a group of persons one legal entity to carry on business—(a) to hold property as a single person; (b) to add or subtract members without changing the legal status of the group; and (c) to make contracts in their corporate capacity without assuming personal liability.

2. Incorporating provides continuity of organization and assets, regardless of changes in management or shareholders, and perpetuity of life of the organization.

3. Independent management or directors aside from stockholders may be provided, and there is a framework for operational freedom to management.

4. Directors do not incur personal liability for any act which they do in good faith within the objects of the company and the powers assigned to them.

5. Incorporating enables large capitalization from many individuals and is the most practical form of business organization for the raising of capital: (a) from sale of capital stock; and (b) borrowing money by issuing bonds and debentures or debenture stock.

6. Liability is limited to corporate assets. Although under the West Virginia Code a corporate physician-employee would remain personally liable for any acts of negligence or malpractice involving his own patients, incorporating limits liability to corporate assets for (a) non-medical acts of negligence (automobile accidents, property damage, etc.) while on corporate business; and (b) any legal action brought against the corporation per se, usually in the realm of public liability, but in which no physician-employee is directly involved.

7. Incorporating legally separates business affairs from personal affairs. Moreover, unlike a partnership, physician-employees of a medical corporation are not personally liable for the torts of their fellow employees. A successful physician who employs a junior associate jeopardizes his accumulated assets should his junior associate become involved in legal action. The complicated legal entanglements that might result from partnership or association would be eliminated by practicing as a corporation.

The Current Status of Professional Corporations

In February, 1965, the Treasury issued new regulations under Sec. 301.7701-2 of the Internal Revenue Code pertaining to *Associations, including organizations labeled "corporations."* These regulations are quite restrictive, and would make it most difficult to qualify "professional corporations" for treatment as corporations for Federal tax purposes.

Although 33 states have enacted special laws to enable professional persons to incorporate, it must be emphasized that these "professional corporation acts" do not permit formation of ordinary business corporations for the practice of medicine. The Internal Revenue Service has maintained that these are "novel" organizations, and refuses to recognize them as true corporations for Federal tax purposes.

The new Treasury regulations should have no application to corporations practicing medicine and surgery under West Virginia Law because these will be ordinary business corporations, formed by virtue of the General Corporation Act, Chapter 31 of the Code. Should such a corpo-

ration ever disengage itself from the practice of medicine, it would continue to function for any and all other purposes specified in the corporate charter. This is in complete distinction to the provisions of the "professional corporation acts" of most states; many of these acts restrict professional corporations to the practice of a specific profession, and any activities not related to such practice are forbidden.

The Importance of HB 662 to West Virginia

Because of HB 662, the greener pastures for group practice are now in West Virginia. This bill improves the general business climate for existing groups and clinics. It should also stimulate formation of new groups and encourage young doctors to remain in West Virginia.

West Virginia now has fewer physicians per 100,000 population than most states. Even more important, the average age of physicians practicing in West Virginia is significantly higher than in neighboring states. Intelligent use of the medical corporation law should enable West Virginia physicians to bolster their ranks and at least partially alleviate this doctor deficit.

Special Advantages for Corporations

The Internal Revenue Service has recognized certain special corporate privileges. These include:

1. Maximum tax of 22 per cent on the first $25,000 of corporate profit.

2. Maximum tax of 48 per cent on all profit above $25,000 per year.

3. Optional employee benefit plans paid with tax-free dollars such as (a) health insurance or group life insurance; (b) death benefits; (c) pension and profit-sharing plans; and (d) key-man insurance.

4. Stock-option plans.

5. Permision to accumulate up to $100,000 in undistributed corporate profits without penalty.

In addition, corporate employees are protected by Social Security, unemployment compensation and state compensation. The degree to which any corporation can participate in the optional benefit programs depends upon its financial position. Unless the corporate net income is sufficient, such programs are not feasible. The advantage of these programs is to permit the corporation to attract and keep employees by providing desirable retirement and health insurance fringe benefits. Because of HB 662, it is felt that groups and clinics incorporated in West Virginia will be able to compete effectively with neighboring states for the services of young physicians, thus improving the over-all physician-patient ratio in this State.

Many young physicians are now oriented to group practice. The idea of a stable organization, such as a corporation, will better appeal to their sense of security than will a partnership or junior association. A corporation, being a permanent organization, offers a young man more hope for future advancement and feasible retirement than is provided by the classical partnership.

Summary

Most groups and clinics will find it advantageous to incorporate to facilitate the business aspects of their practice and to initiate employee benefit programs. These programs will better enable them to attract the services of young physicians.

Special Mission of Drug Makers

The manufacturer of a drug has a special mission in life if his goal is progress and growth and public contribution. He must depend on research even more than promotion if he is to achieve this goal and hold it. For without this exploring of the unknown he can be certain that to mark time is an act designed for those who are suicidally minded businesswise. His is a trust shared by the professional man looking for new ways to heal ailing bodies, by those on whose bodies the healing will occur, and by the investing public as it puts to work its available cash to help this part of our life grow.—Austin Smith, M. D., in Experimental Medicine and Surgery.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 26-28, 1965

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

OUR MEDICAL SCHOOL

As I write this from our Medical School in Morgantown, a dream come true for so many of our State's physicians who worked hard for its fulfillment, we look forward to the realization of our many other hopes and dreams. With three classes graduated, we begin to see the Medical School as the center of the Medical Research, Education and Service complex in our State. The Faculty is passing on the torch of medical knowledge to those who will follow us, inspiring them to practice an even more scientific and proficient medicine, all to the end that those who are now students shall in turn teach those who follow them in the endless chain of this heritage of the free practice of medicine. Each year, at our Annual Convention at The Greenbrier, members of the Faculty have presented an ever increasing display of knowledge in depth to make us all proud of their accomplishments. We hope that this will always prevail.

As we think of our Annual Convention, I would urge you to make your plans now to be at The Greenbrier this year. Our Program Committee has secured an outstanding group of speakers for the scientific program, and the national situation will be covered in full. In my travels throughout the State, I have found some physicians who have never attended an Annual Meeting at The Greenbrier. Why not make it this year? Might I urge you and the members of the Auxiliary to send your reservations to The Greenbrier at your earliest convenience.

As I write this, the U. S. House of Representatives has passed HR 6675, the Medical Care for the Aged Bill. Our only hope now lies in the Senate. We remain unalterably opposed to the King-Anderson Social Security approach incorporated as part of this bill.

In the next few weeks we shall need a united, spirited effort including all those who oppose this socialistic philosophy in a last ditch fight to have this part of the bill amended. We shall then need your help. Our cause is just and we hope you will respond.

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

DR. KENNETH E. PENROD RESIGNS FROM WVU MEDICAL CENTER

Kenneth E. Penrod, Ph.D., Vice President of the University for the Medical Center and Professor of Physiology, has resigned to accept the position as Provost for the Indiana University Medical Center in Indianapolis. Doctor Penrod came to West Virginia University on July 1, 1959. He had served as adviser to Elvis J. Stahr, Jr., then President of the University, concerning Medical Center affairs since February 1, 1959.

Doctor Penrod was born in Blanchester, Ohio. He received his B.S. degree at Miami University (Oxford, Ohio) and his Ph.D. in physiology at Iowa State University. During World War II he served as an aviation physiologist and following the war he taught physiology at Boston University School of Medicine. Doctor Penrod later became Associate Professor of Physiology at Duke University School of Medicine, where he also held the position of Assistant Dean of the Medical School. Before coming to West Virginia University he had had nine years of valuable experience in medical and hospital administration under Dean Wilburt C. Davison, an outstanding medical school administrator.

A vice president was sorely needed at the Medical Center of West Virginia University to supervise the four schools of Medicine, Dentistry, Nursing and Pharmacy. Immediately upon his arrival Doctor Penrod enthusiastically participated in the further structuring and staffing of the components of the Medical Center. In view of the imminent retirement of Dean Edward J. Van Liere, he participated actively in the recruitment of the key clinical personnel.

Doctor Penrod indeed had manifold duties in connection with the development of the Medical Center. His previous experience as a teacher, research scholar and administrator stood him in good stead. He performed his duties in a most efficient and able manner as Dr. Paul A. Miller, President of West Virginia University, in a statement to the press so aptly expressed it: "There is no university enterprise which calls for such vigorous and farsighted leadership as does the organizing of a full-fledged medical center. The rapid rise to prominence of the program at the University is attributed to considerable extent to such qualities possessed by Vice President Penrod."

Doctor Penrod has a challenging job at the University of Indiana, a great institution. We wish him every success and good luck on his new assignment.

REGIONAL MEDICAL EDUCATION

Elsewhere in this issue may be found an article dealing with the cooperative agreement between the School of Medicine of West Virginia University and the Medical College of Virginia. The agreement lasted for 20 years—1942 to 1962. The successful operation of this plan demonstrated the feasibility of interstate cooperation in higher education. The plan served as a model for contracts with several other academic institutions; under contracts arranged through the Southern Regional Education Board, for example, citizens of Virginia may study veterinary medicine in Georgia or Alabama. Since West Virginia University does not have a school of veterinary medicine an agreement has been worked out with Ohio State University and with Oklahoma State University which enables a number of West Virginia students to pursue their studies in either one of these institutions. It is likely that other colleges and universities in the United States also will plan cooperative agreements in certain areas of studies. It is gratifying that the State of West Virginia has been one of the pioneers in the development of such cooperative agreements.

The agreement between the School of Medicine of West Virginia University and the Medical College of Virginia was of great help. The matter of transfer of students at the end of their second year, always a vexing problem, was solved. It was not the first time, however, that the School of Medicine of West Virginia University had a working agreement with another institution. In 1902 an affiliation was established between the School of Medicine of West Virginia University and the College of Physicians and Surgeons of Baltimore (now the University of Maryland School of Medicine). No subsidy was paid by the medical students who lived in Maryland and the agreement lasted until 1912. A joint diploma was issued; indeed, there is still at least one physician in West Virginia who holds such a diploma.

The matter of cooperative agreements with other medical schools is now fortunately of historical interest only to citizens of West Virginia. We now have our own four-year school in a magnificant medical center.

THE CONFUSED CRAWFISH

We are told that professional men must avoid socio-economic and political controversy. As physicians we are advised it is beneath our dignity and improper to openly advocate an uncontrolled economy, the implication being that less dignified members of our society should be the arbiters and planners of our political destiny.

Let us realize, however, that if we do honestly feel that our American System is more than a politician's catch phrase, we must take positive and constructive action to oppose the advocates of socialism who daily strive for more control over the individual. We must recognize Fedicare and similar proposals as sugar coated doses of compulsory socialism and oppose them openly.

If the physicians and lawyers who signed the Declaration of Independence had felt it was beneath their dignity "to become involved," we might not have a choice.

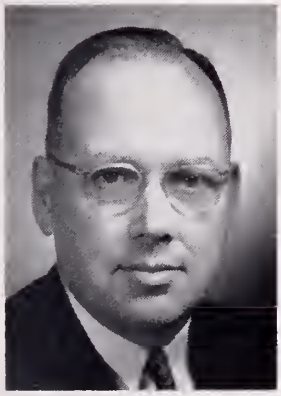
In a recent speech Doctor Nicholas Nyaradi, Director of the School of International Studies at Bradley University, told the following story of some crawfish in his native Hungary. One day, while gaily playing in their sun-drenched stream, they felt the uneasy movement of a fisherman's net which swept them up and out of the water. Their immediate feeling of despair gave way to satisfaction when they found they were not left high and dry but were placed in a bucket of water. Rather than try to escape, they rationalized that after all the sun still shown in slightly and there was enough water. They soon learned that this was only a temporary change when they were sold to a housewife who took them home in a dry, dark paper bag. This desperate situation seemed improved when the housewife placed them in a large pot of water, where they recovered their composure and once more told themselves that their plight was quite tolerable. When the pot was covered and the water became warm the crawfish still convinced themselves that it couldn't happen to them, and the warm water was rather pleasant. The end soon came, and as the water boiled in the pot the housewife raised the lid and discovered that the crawfish were both *red* and *dead.*

The crawfish had no choice — we have.—*Robert F. Lorenzen, M. D., in Arizona Medicine.*

GENERAL NEWS

Drs. Sedgwick and Thurman To Speak At 98th Annual Meeting

The Program Committee has announced that two prominent physicians have been added to the list of guest speakers who will appear on the program at the 98th annual meeting at The Greenbrier in White Sulphur Springs, August 26-28.



Cornelius E. Sedgwick, M. D.

William G. Thurman, M. D.

Dr. Richard J. Stevens of Huntington, the Chairman, said that Dr. Cornelius E. Sedgwick of Boston and Dr. William G. Thurman of Charlottesville, Virginia, have accepted invitations to present papers during the three-day meeting.

Doctor Sedgwick, who is a member of the staff of Lahey Clinic, will appear as a speaker at the first general session on Thursday morning, August 26.

Doctor Sedgwick was born in New York City and received his M. D. degree in 1940 from Cornell University Medical College. He interned and served a residency at Roosevelt Hospital in New York City. He also served a Fellowship in Surgery at the Lahey Clinic, 1947-48.

He served as a Captain in the Medical Corps of the U. S. Army, 1942-45, and joined the staff of the Lahey Clinic in 1948.

He was certified by the American Board of Surgery in 1950 and is a member of the American Medical Association, American College of Surgeons, Boston Surgical Society and New England Surgical Society.

William G. Thurman, M. D.

Dr. William G. Thurman, Professor and Chairman of the Department of Pediatrics at the University of Virginia School of Medicine, will appear as a speaker at the second general scientific session on Friday morning, August 27.

He is a native of Jacksonville, Florida, and received his M. D. degree in 1953 from the McGill University School of Medicine in Montreal. He interned at City Hospital in Columbus, Georgia, and served a residency at Charity Hospital in New Orleans and a fellowship in pediatric hematology at the Tulane University School of Medicine and Children's Hospital of Michigan.

Prior to joining the faculty at the University of Virginia School of Medicine in 1964, Doctor Thurman served as Instructor and Assistant Professor at the Tulane University School of Medicine and Emory University School of Medicine; and as Chairman of the Department of Pediatrics at Memorial Sloan-Kettering Cancer Center in New York City. He also served as Professor of Pediatrics at Cornell University Medical College.

He was certified by the American Board of Pediatrics in 1960 and is a member of the American Society of Hematology, American Society of Human Genetics, American Academy of Pediatrics, and the American Association of Advancement of Science.

Program Nearing Completion

The names of several other guest speakers were announced previously. They are:

Dr. Walter H. Judd, former medical missionary and congressman from Minnesota, who will appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 26; and Dr. R. Gordon Douglas of New York City, Professor of Obstetrics and Gynecology at Cornell University Medical College, who also will present a paper at the first general scientific session.

Presidential Address

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second session of the House of Delegates on Saturday afternoon, August 28. The speaker at the first session of the House on Wednesday afternoon, August 25, will be Dr. James Z. Appel of Lancaster, Pennsylvania, who will be installed as President of the American Medical Association in June.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Emphysema Deaths Quadrupled In Last 10 Years

Deaths from chronic pulmonary emphysema have more than quadrupled in the nation during the past 10 years.

State Health Director N. H. Dyer said the over-all picture of respiratory diseases has changed remarkably during the past two decades.

Although tuberculosis is still a major problem in West Virginia, he pointed out that the disease has declined sharply in the nation while lung cancer has increased. In addition, a group of non-specific respiratory conditions have emerged, killing 27,000 Americans and contributing to the death of another 43,000 during 1962.

Doctor Dyer noted that in the classification of non-specific respiratory conditions pulmonary emphysema is the leading cause of death. In 1962, there were 12,350 emphysema deaths reported in the United States as compared to 115 in 1935. There are now an estimated one million cases in the nation of which approximately 60,000 will die in 1965.

He indicated that estimates show that one of every 14 workers in the United States between 40 and 65 is disabled by emphysema. It accounts for more social security disability payments to workers from 50 to 64 than any one single cause other than heart disease.

In 1963, West Virginia reported 177 deaths with the major cause of death listed as emphysema. Doctor Dyer pointed out that it is most likely that this does not reflect the extent of the disease.

Of those 177 deaths in the state, the largest single number—68—was in the 60 to 69 age group, the second largest 55 in the 70 to 79 age group.

In another health matter, Doctor Dyer said that results from the survey taken in the state show that immunization levels for smallpox are very low.

The survey made in 29 counties shows that only 39.5 per cent of the children under five have ever been vaccinated against smallpox. This ranges from 32.1 per cent in rural areas to 46.8 per cent in urban areas.

Pennsylvania Allergy Assn. Meeting In Altoona, May 14-16

Physicians in West Virginia have been extended a cordial invitation to attend the 17th Annual Meeting of the Pennsylvania Allergy Association which will be held at the Holiday Inn in Altoona, Pennsylvania, May 14-16.

One of the guest speakers will be Dr. Howard G. Rapaport of New York City, who will discuss "The Allergist's Role." Other speakers will include Drs. Phillip Blank, Macy I. Levine and Mayer A. Green, all of Pittsburgh, and Dr. Jose M. Quintero of Harrisburg.

Further information may be obtained by writing Dr. Philip Blank, 3028 Brownsville Road, Pittsburgh, Pennsylvania.

Gov. Hulett C. Smith is shown signing into law several bills of interest to the medical profession which were passed during the 1965 session of the Legislature. Present to witness the signing of the bills were, left to right, Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association; Del. J. Bernard Poindexter of Huntington; and William H. Lively, Executive Secretary of the State Medical Association. Doctor Poindexter, a practicing dentist in Huntington who has served in the House of Delegates for five terms, introduced and was instrumental in the passage of several bills sponsored by the State Medical Association.

Doctor Bateman Reappointed Mental Health Director

Gov. Hulett C. Smith recently reappointed Dr. Mildred Mitchell-Bateman as State Director of Mental Health for an indefinite term. Doctor Bateman was first appointed to the position in December of 1962 by former Gov. W. W. Barron.

Before assuming her present duties, Doctor Bateman served as clinical director and superintendent of Lakin State Hospital. From August of 1960 to 1962, she was supervisor of professional services in the State Department of Mental Health.

Doctor Bateman was graduated from Johnson C. Smith University and she received her M. D. degree in 1946 from the Woman's Medical College of Pennsylvania. She completed a three-year residency and fellowship in 1955 at the Menninger School of Psychiatry in Topeka, Kansas, and she was certified by the American Board of Psychiatry and Neurology in 1957.

Rheumatic Fever Program To Be Expanded

The West Virginia Heart Association announced recently a prevention program for state residents who have or have had rheumatic fever or allied diseases of the heart will be expanded to include all 55 counties in the next few months.

The new program, which started in Kanawha County as a pilot project, will supplement the penicillin program which has been sponsored by the State Department of Health and the Heart Association.

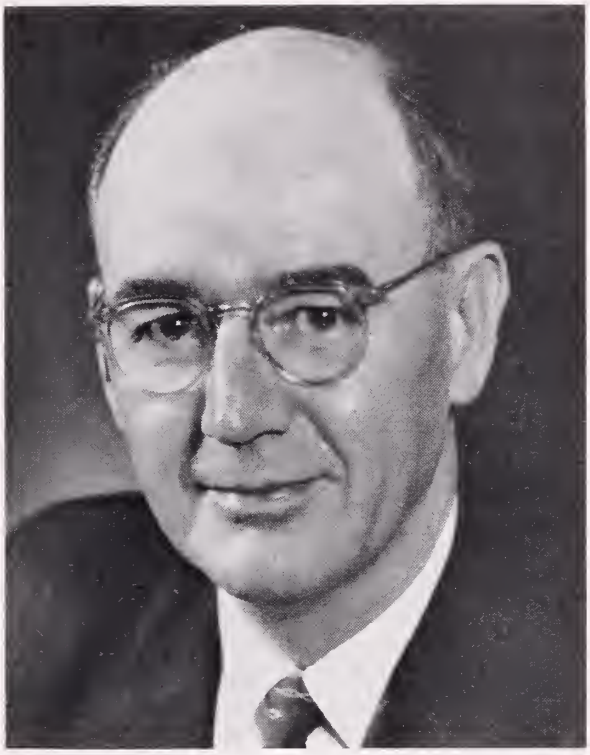
Medically indigent persons have been benefiting from the current program which was launched to assist those unable to afford prophylaxis over an extended number of years because of financial reasons.

Participating physicians will decide which patients should be participating in the program, and special prescription forms will be distributed to the doctors.

Wheeling BS Plan Receives Rate and Fee Increase

On March 29, 1965, the West Virginia Insurance Commissioner, Harlan Justice, approved a rate and physicians' fee increase for the West Virginia Medical Service, Inc. (Blue Shield) of Wheeling, West Virginia. The over-all increase in the rates is approximately 31 per cent and the increase in the physicians' fees is approximately 20 per cent. The rate increase is effective July 1, 1965, while the increase in physicians' fees is retroactive to January 1, 1965.

The West Virginia Medical Service, Inc. services a very large area which consists of all the Northern Panhandle counties, the Fairmont area, and all of the Eastern Panhandle counties as far south as Pocahontas and Webster counties, a total of 23 counties. There are approximately 800 physicians in the area and approximately 99 per cent of them have signed a participating agreement with the West Virginia Medical Service, Inc.



James Z. Appel, M. D.

Dr. James Z. Appel Honor Guest At 98th Annual Meeting

Dr. James Z. Appel of Lancaster, Pennsylvania, who will be installed as President of the American Medical Association at the annual convention in New York City in June, will be an honor guest at the 98th annual meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, said that Doctor Appel will be the guest speaker before the first session of the House of Delegates on Wednesday afternoon, August 25, the day preceding the formal opening of the meeting.

Doctor Appel was born in Lancaster and was graduated from Franklin and Marshall College. He received his M. D. degree in 1932 from the University of Pennsylvania School of Medicine. He is currently serving as president of the staff of the Lancaster General Hospital and as director of health services at Franklin and Marshall College.

He was elected a Delegate to the American Medical Association in 1945 and was named a member of the Board of Trustees in 1957. He had been Vice Chairman of the Board of Trustees since 1962, a position he relinquished upon being named President Elect at the clinical convention in Miami Beach.

Doctor Appel is Chairman of the Joint Commission on Accreditation of Hospitals and has served for the past two years as a United States Delegate to the World Health Organization.

57 WVU Medical School Students Receive Intern Appointments

Fifty of the 57 students comprising the fourth class scheduled to receive M. D. degrees at the West Virginia University School of Medicine received their first choice internship appointments.

The 57 students will graduate May 31 and begin their internships on July 1.

Dean Clark K. Sleeth said 21 students will intern in West Virginia hospitals and three in military hospitals. The remaining 33 will intern in 12 other states.

A list of the students, their home towns and internships accepted follows:

West Virginia University Hospital—Charles Baisden, Stollings; James Dollison, Fairmont; Ivan Harwood, Huntington; William C. Stewart, Jr., Charleston, and Sharon Woods, Mullens.

Charleston Memorial Hospital—Billie Atkinson, Reedy; Larry Curnutte, Kenova; Clare Edman, Buckhannon; Trevelyn F. Hall, Jr., Fairmont; David Hess, Bridgeport; John Osborne, St. Albans; Joe Rhudy, Lewisburg; John Rizzo, Farmington; Hubert Shaffer, Morgantown; Jerry Shamblin, South Charleston, and Larry Stemple, Philippi.

Ohio Valley General Hospital, Wheeling—Thomas Beynon, Weirton; John Holman, Wheeling, and Merrill Wymer, Jane Lew.

Cabell-Huntington Hospital—Thomas Mearns, Summersville.

Wheeling Hospital—Thomas Ritz, Wheeling.

The Toledo Hospital, Ohio—James Anderson, Belva.

Mercy Hospital, Baltimore—Werner Beck, Philadelphia, and Eldon Hawbaker, Martinsburg.

Allegheny General Hospital, Pittsburgh—Saul Berg, Pittsburgh.

Mound Park Hospital, St. Petersburg, Florida—Howard Blankenship, Moundsville; Dianne Rechtine, Kingwood, and Robert Sams, Parkersburg.

Army Medical Service, Brooke General Hospital, San Antonio, Texas—Raymond L. Brown, Jr., Welch.

University of Minnesota Hospital, Minneapolis—Erskine Caperton, Mt. Hope.

Lankenau Hospital, Philadelphia—Robert Carroll, Westport, Connecticut, and Robert Hobbs, Chester.

Medical College of Virginia, Richmond—Eugene Dorsey, Huntington.

U. S. Naval Hospital, Jacksonville, Florida—Donald Farmer, Athens.

St. Josephs Hospital, Denver—Robert Ferrell, Fairmont, and Paul Gregg, Sistersville.

Cook County Hospital, Chicago—Frank J. Zsoldos, Charleston.

St. Elizabeth Hospital, Dayton, Ohio—Joseph Gregori, Pittsburgh.

San Francisco General Hospital—Philip Hopewell, Fairmont.

Children's Hospital, Akron, Ohio—Sandra L. Kovach, Morgantown.

Army Medical Service, Madigan General Hospital, Tacoma, Washington—Richard Landes, Riverton.

University of Wisconsin Hospital, Madison—Linda Lewis, Beech Bottom.

Lakeland General Hospital, Florida—Robert Likens, Coalwood.

Monmouth Medical Center, New Jersey—Anne Lorenzo, Charles Town.

Shadyside Hospital, Pittsburgh—Clarence Neptune, Fairmont.

Good Samaritan Hospital, Dayton—Robert Petres, Fairmont.

Methodist Hospital, Indianapolis—Sanford Plevin, Weirton.

Norfolk General Hospital—John Ralsten, Beckley, and Harvey Reisenweber, Baltimore.

Akron General Hospital—Alex Sabo, Morgantown.

University of Pennsylvania Hospital, Philadelphia—Norman Silvers, Flushing, New York.

Bethesda Hospital, Cincinnati—Sally Taylor, Alloy.

Akron City Hospital—Edward Thompson, Williamson, and Albert Turbessi, Scranton, Pennsylvania.

Grant Hospital, Columbus, Ohio—C. Jane Toothman, Parkersburg.

Good Samaritan Hospital, Cincinnati—Robert Watson, Gary.

Ancker Hospital, St. Paul, Minnesota—Thomas Weier, Bluefield.

Coach Richard W. Corbitt (M. D.)

Friends and patients of Dr. Richard W. Corbitt of Parkersburg have addressed him as "Coach" for a number of years due to his dedicated interest in the fortunes of the athletic teams at Parkersburg High School.

Now it's official!

During a recent meeting members of the West Virginia Coaches Association elected "Coach" Corbitt to honorary life membership in the Association.

Meeting of Pathologists Held In Beckley on April 10

The annual spring meeting of the West Virginia Association of Pathologists was held at Appalachian Regional Hospital in Beckley on April 10.

Several papers were presented at the meeting and Dr. Victor M. Napoli of Morgantown was in charge of a seminar.

Drs. Werner A. Laqueur and Jamil Ahmed of Beckley served as hosts for the one-day meeting.

PG Course in Clinical Cardiology

The Cleveland Clinic Educational Foundation will present a postgraduate course in Clinical Cardiology, May 19-20.

The registration fee is $30 and a deposit of $5 is requested with registration. The fee will be waived for residents and interns if arrangements are made prior to the course and if space is available.

Information may be obtained by writing to the Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Dr. William L. Cooke To Preside At National TB Meeting

Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, will preside at several sessions during the 61st annual meeting of the organization at the Palmer House in Chicago, May 30-June 2.

Doctor Cooke will preside at the opening general session on Sunday, May 30; at an awards session on May 31; at a luncheon on Wednesday, June 2; and at a business session that same day.

A paper entitled "Immunochemical Analysis of Lung-Reactive Antibodies," which was prepared by three members of the faculty of the West Virginia University Medical Center, will be presented on June 1. The co-authors are Drs. Charles E. Andrews, Robert G. Burrell and James E. Hagadorn.

Rocky Mountain Cancer Conference In Denver, July 16-17

The 19th Annual Rocky Mountain Cancer Conference will be held in Denver, July 16-17.

Participants will include Dr. James Z. Appel, President Elect of the American Medical Association, and Dr. Murray M. Copeland, President of the American Cancer Society.

Further information may be obtained by writing to Rocky Mountain Cancer Conference, 1809 East 18th Avenue, Denver, Colorado 80218.

PG Course in Internal Medicine

A postgraduate course on "Basic Principles in Internal Medicine" will be presented by the American College of Physicians in Iowa City, Iowa, June 7-11.

The purpose of the course is to review developments and newer concepts of disease in internal medicine for the practicing internist. Lectures will be supplemented with panel discussions, case presentations and exhibits.

Dr. William B. Bean, Professor of Medicine at the University of Iowa College of Medicine, is director of the course. Registration forms and additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Cancer Society Meeting in Philadelphia

The American Cancer Society's 1965 Scientific Session on "Hormones and Chemotherapy for Cancer—A Critical Appraisal," will be held at the Drake Hotel in Philadelphia on June 16.

Sessions will be open to all members of the medical profession and to students with no advance registration or registration fee required.

Inquiries concerning the program should be sent to: Director, Professional Education, American Cancer Society, Inc., 219 E. 42nd St., New York, N. Y. 10017.

Dr. Albert C. Esposito of Huntington, right, President of the West Virginia State Medical Association, presents a check for $13,051.20 from the American Medical Association Education and Research Fund to Dr. Edward G. Stuart, Assistant Dean of the West Virginia University School of Medicine. Doctor Esposito made the presentation during a ceremony held at the WVU Medical Center in Morgantown on April 6. The grant is part of $1,313,559 contributed throughout the country by physicians, their families and friends to the AMA-ERF.

Pharmaceutical Assn. Publishes Revised Pamphlet

The Pharmaceutical Manufacturers Association recently published a new edition of "Key Facts," an assortment of information on the prescription drug industry.

The pamphlet contains nine up-to-date charts which underscore trends in the conquest of disease and the industry's contributions to the health effort. As an aid to speakers, writers, government officials and others concerned with the drug industry, information is categorized under the headings of prices, competition, safety, research and accomplishments.

Copies may be obtained by writing the Public Information office, Pharmaceutical Manufacturers Association, 1155 Fifteenth Street, N. W., Washington, D. C. 20005.

Medical Meetings, 1965

The following is a partial list of national, state and district medical meetings scheduled for 1965:

May 9-14—Ohio State Medical Assn., Columbus.
May 15-16—W. Va Radiological Society, Beckley.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia

New Association Members

Dr. David E. Edwards, WVU Health Service, Morgantown (Monongalia). Doctor Edwards, a native of Johnstown, Pennsylvania, received his M. D. degree in 1951 from the University of Maryland School of Medicine. He interned at the U. S. P. H. S. Hospital in Norfolk, Virginia, 1951-52, and served a residency at Spring Grove Hospital in Catonsville, Maryland. He was previously located in Baltimore and Keyser and his specialty is psychiatry.

* * *

Dr. Robert S. English, 235 High Street, Morgantown (Monongalia). Doctor English, a native of Pittsburgh, was graduated from Grove City College and received his M. D. degree in 1959 from the Hahnemann Medical College. He interned at Allegheny General Hospital in Pittsburgh, 1959-60, and served residencies at Hahnemann Medical College and the University of Pennsylvania, 1960-63. He is currently serving as Clinical Instructor in Dermatology at the WVU School of Medicine.

* * *

Dr. Grady H. McRae, Bluefield Clinic, Bluefield (Mercer). Doctor McRae, a native of Burkburnett, Texas, was graduated from the University of Texas and received his M. D. degree from the University of Texas at Galveston. He interned at Harris Hospital in Ft. Worth, Texas, 1954-55, and served a residency at Kauikeolani Children's Hospital, Honolulu, Hawaii, 1955-56. He also served a residency at Beckley Memorial Hospital, 1963-64. He served as a Lt. Commander in the Medical Corps of the United States Navy and his specialty is pediatrics.

* * *

Dr. Barry M. Smith, Green Bank (Greenbrier Valley). Doctor Smith, a native of Charles Town, was graduated from Shepherd College and received his M. D. degree in 1963 from the West Virginia University School of Medicine. He interned at Deaconess Hospital in Spokane, Washington, 1963-64, and was licensed to practice in West Virginia in 1965. He is engaged in general practice.

* * *

Dr. Alvin L. Watne, WVU Medical Center, Morgantown (Monongalia). Doctor Watne, a native of Shabbona, Illinois, was graduated from the University of Illinois and received his M. D. degree in 1952 from the University of Illinois College of Medicine. He interned at Indianapolis General Hospital, 1952-53, and served a residency at the University of Illinois Research and Education Hospital, 1954-58. He received an M. S. degree in surgery in 1956 from the graduate school of the University of Illinois College of Medicine. He was previously located at Roswell Park Memorial Institute in Buffalo, New York, and is currently serving as Associate Professor of Surgery at the WVU School of Medicine.

Integrity without knowledge is weak and useless, and knowledge without integrity is dangerous and dreadful.—Samuel Johnson.

Dr. Philip Sprinkle Will Join Medical School Staff

Dr. Philip Sprinkle of Charlottesville, Virginia, has been appointed Associate Professor of Surgery and Chairman of the newly established Division of Otolaryngology at the West Virginia University School of Medicine. He will assume his new duties on or before July 1.

Philip Sprinkle, M. D.

Doctor Sprinkle, a native of Greensboro, North Carolina, received his M. D. degree in 1953 from the University of Virginia School of Medicine. Following his internship, he was engaged in general practice for several years in Martinsville, Virginia. He served residencies in general surgery and otolaryngology at Watts Hospital in Durham, North Carolina, and the University of Virginia Hospital, 1960-64. He is currently serving as clinical assistant professor of otolaryngology at the University of Virginia. He is certified by the American Board of Otolaryngology.

It also was announced that an ear-nose-throat clinic will be placed into operation in the out-patient department at the Medical Center and a portion of University Hospital will be set aside for otolaryngology cases.

Dr. C. A Hoffman Elected to Membership On BS Executive Committee

Dr. C. A. Hoffman of Huntington was elected to membership on the Executive Committee of the Board of Directors of the National Association of Blue Shield Plans during the recent annual meeting of the organization in San Francisco.

Doctor Hoffman, who is a past president of the West Virginia State Medical Association, was elected to membership on the Board of Directors several months ago. There are seven members on the Executive Committee, including the officers of the Association.

He serves on the Board of Directors as physician representative for Blue Shield Plans in West Virginia, Kentucky, Maryland, Virginia, North Carolina, South Carolina and the District of Columbia.

Doctor Hoffman is currently a member of the House of Delegates of the American Medical Association and has served since 1962 as a member of the AMA Committee on Insurance and Pre-Payment Plans.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

LOMOTIL®

INITIAL LOMOTIL LIQUID DOSAGE*

Age	
3-6 mo.	½ tsp. t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adult	2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.)

*Based on 4 cc. per average teaspoonful.
Note: After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate ..... 0.025 mg.

Precautions
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Cautions and Side Effects
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.
Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

WVU Medical Center
—News—

• Compiled from material furnished by Arthur V. Cierva, Director, Medical Center News and Information Services, Morgantown, West Virginia.

Two members of the faculty of the West Virginia University School of Medicine were among the speakers at a Science Writing Symposium held at the Medical Center in Morgantown, April 2-3.

Dr. Alvin L. Watne, Associate Professor of Surgery, showed slides to illustrate his paper on "Problems of Metastases in Cancer Management." Dr. Charles E. Andrews, Professor of Medicine, participated as a member of a panel that discussed smoking and its suspected relationship with lung cancer.

Three faculty members in other West Virginia University departments also presented papers. Dr. Harold A. Wilson, Professor of Bacteriology, discussed "Sewage Decomposition in Acid Mine Waters."

Dr. Edward F. Byars, Professor of Theoretical and Applied Mechanics, and Dr. James H. McElhaney, Assistant Professor of Theoretical and Applied Mechanics, presented an interesting paper on "Engineering in Medicine."

Dr. Patrick Thaddeus, a physicist at the Goddard Institute for Space Studies in New York, was the speaker at the banquet. He discussed "Recent Advances in Space Science."

Science writers and other news and health personnel attended the symposium.

Honor Society Installs Nine

Eight medical students and one faculty member were installed recently as members of the West Virginia Alpha Chapter of Alpha Omega Alpha, honor medical society.

The faculty member installed was Dr. Charles E. Andrews, Professor of Medicine. These students also were installed:

Seniors—Joseph Rhudy, Lewisburg; Linda Lewis, Beech Bottom; Erskine Caperton, Mount Hope; Billie Atkinson, Reedy; and Harvey Reisenweber, Baltimore, Maryland.

Juniors—Samuel Strickland, Summersville; Paul M. Chikos, Logan; and Donald Glass, Uniontown, Pennsylvania.

Dr. William B. Bean, noted physician, writer and lecturer from the University of Iowa, was the speaker at a banquet held at the Lakeview Country Club.

Student Research Convocation

The West Virginia University School of Medicine will hold a Student Research Convocation on May 7 as a means of stimulating individual initiative among medical students.

Dr. Clark K. Sleeth, Dean of the School of Medicine, said students were encouraged to prepare papers for presentation at the convocation. A special faculty committee will serve as judges and a special award will be given to the student presenting the best paper.

The prize—consisting of $100 and an engraved medal —will be named the Edward J. Van Liere Award in honor of the Dean-Emeritus of the School of Medicine. Doctor Van Liere retired as Dean in 1961 and now serves as Professor of Physiology and Resident Professor of Obstetrics.

Opossum Research

Opossums have found a niche in the medical research effort at the West Virginia University School of Medicine.

Dr. Eugene LaPlante, Resident in Surgery, said the opossum's distinctive reproductive process makes the animal valuable for research, particularly in the transplantation of organs.

In one experiment, Doctor LaPlante grafted skin from a mother opossum's ear to the back of her offspring. It is hoped that the transplanted skin will induce a tolerance for foreign tissue into the baby opossums.

PG Course in Anesthesiology

Anesthesiologists from West Virginia and other states attended a postgraduate course in Morgantown, April 3-4.

The fourth annual course was sponsored by the West Virginia Society of Anesthesiologists and the Division of Anesthesiology of the West Virginia University School of Medicine.

Dr. Wade H. Rardin of Beckley, President of the West Virginia Society, participated in the program. He was joined by several visiting lecturers and members of the staff of the Division of Anesthesiology.

The address of welcome was delivered by Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery.

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PHYSICIANS NATIONWIDE, INC.

"An association of Northwestern Mutual agents offering a professional service to the physician for insurance and financial planning."

Regional Vice Presidents
FOR WEST VIRGINIA

HUGH THOMPSON

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OUR OBJECTIVE:

To offer a professional service to the physician for insurance and financial planning.

QUESTIONS:

(1) Do you think it makes good sense to PLAN your financial future?
(2) Are you satisfied with the planning you have done to date?
(3) Does your present program guarantee the maximum for self and heirs the minimum for Uncle Sam?

MAIL COUPON

To: **Hugh Thompson & Pete White,** 1000-1003 Security Building, Charleston, West Virginia 25301

Without obligation, I would like to meet with you, see your services and discuss proper financial planning. You may call for an appointment.

Name (print) _____ *Address* _____

(O) _____ *(H)* _____ *Date of birth* _____
Phone

The Month in Washington

THE House has passed legislation (H.R. 6675) to provide federal health care for the aged that goes much farther than the King-Anderson bill the Johnson Administration originally asked Congress to approve.

The key House vote as far as the King-Anderson provision was concerned was on substitution of a Republican insurance plan which included some features of Eldercare which was sponsored by the American Medical Association. The vote was 236 to 191 against the GOP substitute.

The vote on final House passage of H.R. 6675 was 313 for and 115 against.

After nearly two months of hearings behind closed doors, the House Ways and Means Committee on March 23 approved the "three-layer cake" program which included a modified version of the King-Anderson bill, a supplementary government-subsidized health insurance plan for the elderly and an extensive expansion of the federal-state Kerr-Mills Program.

The committee vote was strictly on party lines—17 Democrats for the catch-all package and eight Republicans against it.

No Vote on Eldercare Bill

Despite a tremendous flood of letters from the public in favor of the AMA's Eldercare plan for comprehensive health insurance for the elderly under Kerr-Mills, the House Committee didn't take a vote on H.R. 3727—the Herlong-Curtis Eldercare bill.

President Johnson quickly gave Administration support to the committee bill and asked for speedy approval by Congress.

The Administration-approved legislation would provide compulsory social security coverage, effective January 1, 1966, for self-employed physicians and for interns and residents.

It also would increase, retroactive to January 1, 1965, social security cash benefits by seven per cent across-the-board with a minimum increase of $4 a month for an individual.

The wage base on which social security taxes are paid would be increased on January 1, 1966, from $4800 to $5600, and on January 1, 1971, to $6600.

The social security tax paid by employees and employers each would be increased next January 1 from the present $174 per year to $243.60. The tax on a self-employed individual would be increased from $259.20 to $355.60.

• **From the Washington Office of the American Medical Association.**

In 1971, when the taxable wage base would be increased to $6600, the employee and employer would be paying a tax of $323.40 each, and the self-employed individual would be paying a tax of $468.60.

The tax rate on the new wage bases would be increased as follows:

	Self-Employed		Employee-Employer (Each)	
	Present	Proposed	Present	Proposed
1966	6.2%	6.35%	4.125%	4.35%
1967	6.2%	6.50%	4.125%	4.50%
1968	6.9%	6.50%	4.625%	4.50%
1969-72		7.1%		4.90%
1973-75		7.55%		5.35%
1976-79		7.60%		5.40%
1980-86		7.70%		5.50%
1987 & thereafter		7.80%		5.60%

The legislation would provide:

King-Anderson Section

Eligible: Persons 65 years and older.

Benefits: Inpatient hospital services for up to 60 days in semi-private accommodations (two-to four-bed) during a spell of illness, subject to a deductible, which until 1969 would amount to $40.

—Post-hospital extended care services for up to 20 days during any spell of illness in a facility which has in effect a transfer agreement with one or more hospitals or which a state agency finds has attempted to enter into such an agreement. This benefit could be extended for a period of up to an additional 80 days under circumstances described below.

—Post-hospital home health services for up to 100 visits during a one-year period following hospitlization.

—Outpatient hospital diagnostic services during a 20-day period subject to a deductible equal to one-half the deductible for inpatient hospital services.

Inpatient hospital services, post-hospital home health services, and outpatient hospital diagnostic services would begin in July 1, 1966. Post-hospital extended care services would begin on January 1, 1967.

(Continued on Page xxxii)

nd in previously treated
ertensive patients...

Uh-huh.

Regroton improved response
in 76 out of 80...

huh.

...reducing mean arterial pressure
from 135 to 112 mm. Hg.

Uh-huh.

t you even want to try it, Doctor?

I've *already* got eleven patients
doing fine on Regroton.

Why didn't you say so in the
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Superior to other antihypertensives
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osition: Each tablet contains chlorthalidone, m, and reserpine, 0.25 mg.
indications: History of mental depression, ensitivity, and most cases of severe renal atic diseases.
ng: Discontinue 2 weeks before general esia, 1 week before electroshock therapy, depression or peptic ulcer occurs.
tions: Reduce dosage of concomitant anti-ensive agents by one-half. Discontinue if N rises or liver dysfunction is aggravated. lyte imbalance and potassium depletion cur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
Side Effects: Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

Average Dosage: One tablet daily with breakfast.
Availability: Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York RE-3455

Annual Audit, 1964

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1964 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
500 Kanawha Banking & Trust Building
Charleston, West Virginia 25301

West Virginia State Medical Association
Charleston, West Virginia

We have examined the summary statement of cash receipts and disbursements of the West Virginia State Medical Association and the statements of cash receipts and disbursements by funds for the year ended December 31, 1964, and the statement of securities owned at December 31, 1964. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying summary statement of cash receipts and disbursements and the statements of cash receipts and disbursements by funds present fairly the recorded cash transactions of the West Virginia State Medical Association for the year ended December 31, 1964, and securities owned by the Association at December 31, 1964.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
March 25, 1965

SUMMARY STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1964

CASH IN BANK—JANUARY 1, 1964		$ 29,912.01
RECEIPTS		
Dues—see footnote	$ 59,252.00	
Interest on U. S. Bonds	800.00	
Collection Commission on A.M.A. Dues	559.58	
Advertising	20,355.04	
Emblems sold	46.00	
Subscriptions	616.00	
Exhibit space sold	8,051.50	
Dues collected for A.M.A.	52,290.00	
Interest on savings	257.24	
Contributions to General Fund	500.00	
Contributions to Medical Scholarship Fund	585.00	
Refunds	3,108.25	
Employee contributions—Employee Benefit Plan	365.28	
Proceeds sale of U. S. Bonds	11,167.74	
Total Receipts		157,953.63
		187,865.64
DISBURSEMENTS		
General Fund	57,190.79	
Medical Journal Fund	30,820.73	
Convention Fund	10,922.37	
Dues forwarded to A.M.A.	52,290.00	
Medical Scholarship Fund	10,823.98	
Public Service Fund	690.69	
Total Disbursements		162,738.56
CASH IN BANK—DECEMBER 31, 1964		$ 25,127.08

	1-1-1964	12-31-1964
Cash in bank—Savings Account	6,367.25	6,624.49
Cash in bank—Checking Account	23,544.76	18,502.59
Total	$ 29,912.01	$ 25,127.08

Membership dues as reflected above includes 1965 dues of $3,750.00 collected in December, 1964.

THE WHEELING CLINIC

EOFF AT 16th STREET

WHEELING, WEST VIRGINIA

General Surgery:
J. O. Rankin, M. D.
C. D. Hershey, M. D.
E. C. Voss, M. D.

Ophthalmology:
W. F. Park, M. D.
G. J. Pentecost, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Nancy Fondriest, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Manager:
Lester L. Cline

GENERAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE—JANUARY 1, 1964		$ 4,262.02
RECEIPTS		
Dues (Allocated to General Fund)—see footnote	$ 48,818.00	
Interest on U. S. Bonds	625.00	
Collection Commission on A.M.A. Dues	559.58	
Contributions	500.00	
Refunds—Miscellaneous	723.18	
Refunds—A.M.A	2,170.07	
Employee contribution—Employee Benefit Plan	365.28	
Proceeds sale of U. S. Bonds	11,167.74	
Total Receipts		64,928.85
		69,190.87
DISBURSEMENTS		
Salaries—Executive Secretary (75%)	9,874.98	
—Office	14,402.46	
Office supplies and expense	3,759.36	
Office rent	3,180.00	
Library expense	280.24	
Telephone and telegraph	1,451.28	
Postage	1,716.77	
Travel	1,992.05	
Legal and auditing	1,095.00	
Legislative bulletins and expense	1,417.79	
Payroll taxes	811.44	
Unemployment tax	230.51	
Mimeographing	1,179.81	
Expense of Council and Committee meetings	9,127.03	
Miscellaneous expense	2,852.98	
Employee Benefit Plan	1,462.38	
Office equipment and furnishings	387.85	
Advertising	1,968.86	
Total Disbursements		57,190.79
BALANCE—DECEMBER 31, 1964		$ 12,000.08

Membership dues allocated to the General Fund as reflected above includes 1965 dues of $2,812.50 collected in December, 1964.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE—JANUARY 1, 1964 (Deficit)		($ 2,803.29)
RECEIPTS		
Advertising	$ 20,355.04	
Emblems sold	46.00	
Subscriptions	616.00	
Refunds and discounts	20.00	
Dues (allocated to Journal Fund)—see footnote	262.50	
Total Receipts		21,299.54
		18,496.25
DISBURSEMENTS		
Printing	21,235.66	
Engraving	1,058.28	
Postage	1,079.14	
Salaries and editing	6,498.32	
Miscellaneous	949.33	
Total Disbursements		30,820.73
BALANCE—DECEMBER 31, 1964 (deficit)		($ 12,324.48)

Membership dues allocated to the Medical Journal Fund as reflected above includes 1965 dues of $262.50 collected in December, 1964.

CONVENTION FUND

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE—JANUARY 1, 1964		$ 3,465.34
RECEIPTS		
Exhibit space sold	$ 8,051.50	
Dues (allocated to Convention Fund)—see footnote	2,974.50	
Refunds:		
Convention Golf Tournament	195.00	
Total Receipts		11,221.00
		14,686.34

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HERNDON P. HARDING, M.D.

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RICHARD L. BAUMGARTNER, M.D.

JAMES L. HAGLE, M.B.A.
Administrator

GRACE M. COLLET, Ph.D.
KENNETH S. CROFOOT, Ed.D.
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MARY JANE McCONAUGHEY, M.S.W.
JUDITH L. VERES, M.S.W.
Psychiatric Social Workers

PAULINE L. TOOILL, R.R.L.
Medical Record Librarian

ESTHER L. SIMPSON, R.N.
Director of Nurses

ANN HARPER, B.S., O.T.R.
Occupational Therapist

JAMES MYERS, B.S., M.Ed.
Recreational Therapist

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DISBURSEMENTS		
Supplies and labor	5,647.26	
Travel	419.40	
Entertainment	3,232.97	
Telephone and telegraph	646.74	
Advance Convention Golf Tournament	250.00	
Reporting	290.00	
Miscellaneous	186.00	
Auxiliary Convention expense	250.00	
Total Disbursements		10,922.37
BALANCE—DECEMBER 31, 1964		$ 3,763.97

Membership dues allocated to the Convention Fund as reflected above includes 1965 dues of $225.00 collected in December, 1964.

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE—JANUARY 1, 1964	$ None
RECEIPTS	
Dues collected for A.M.A.	52,290.00
	52,290.00
DISBURSEMENTS	
Dues forwarded to A.M.A.	52,290.00
BALANCE DUE A.M.A.—DECEMBER 31, 1964	$ None

PUBLIC SERVICE FUND

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE STATE ASSESSMENTS—JANUARY 1, 1964 (deficit)	($ 61.60)
RECEIPTS	
Assessments	None
	(61.60)
DISBURSEMENTS	
Conference and general expense	690.69
BALANCE STATE ASSESSMENTS—DECEMBER 31, 1964 (deficit)	($ 752.29)

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements Calendar Year 1964

BALANCE—JANUARY 1, 1964		$ 25,049.54
RECEIPTS		
Dues (allocated to Medical Scholarship Fund)—see footnote	$ 7,197.00	
Contributions	585.00	
Interest on U. S. Treasury Bonds	175.00	
Interest on Savings Account	257.24	
Total Receipts		8,214.24
		33,263.78
DISBURSEMENTS		
Scholarship installment	10,500.00	
Travel, printing and miscellaneous expense	323.98	
Total Disbursements		10,823.98
BALANCE—DECEMBER 31, 1964		$ 22,439.80
Balance in Savings Account	6,624.49	
Balance in General Fund Checking Account	15,815.31	
Total	$ 22,439.80	

Membership dues allocated to the Medical Scholarship Fund as reflected above includes 1965 dues of $450.00 collected in December, 1964.

SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1964

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27846F	12-15-67/72	$10,000.00
U. S. Treasury 2½%	70011A	12-15-67/72	1,000.00
U. S. Treasury 2½%	70012B	12-15-67/72	1,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	72361A	12-15-67/72	1,000.00
U. S. Treasury 2½%	22646F	12-15-67/72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67/72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67/72	1,000.00
Series "J"	Q22297J	1- 1-1968	25.00
Series "J"	Q22298J	1- 1-1968	25.00
Total			$ 19,550.00

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A fully charged medium size rechargeable handle gives usable light far longer than regular batteries of the same size.

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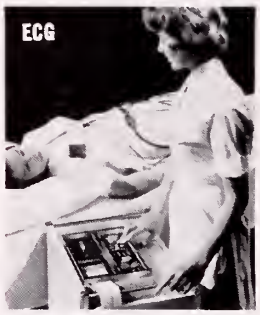

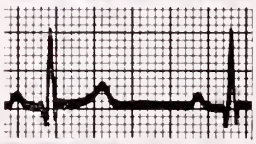

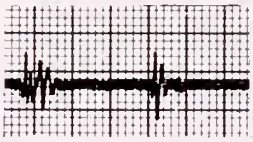

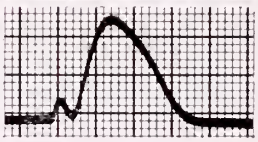

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♦

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HUNTINGTON, WEST VIRGINIA

ANNUAL AUDIT—(Continued)

SCHEDULE OF BONDS SOLD DECEMBER 21, 1964

U. S. Treasury 2½%	27070L	12-15-67/72	$10,000.00
U. S. Treasury 2½%	19534D	12-15-67/72	500.00
U. S. Treasury 2½%	20707H	12-15-67/72	500.00
U. S. Treasury 2½%	20935E	12-15-67/72	500.00
U. S. Treasury 2½%	21421A	12-15-67/72	500.00
U. S. Treasury 2½%	21914D	12-15-67/72	500.00
Total			$ 12,500.00

COMPARATIVE SCHEDULE OF CASH AND BONDS AS OF DECEMBER 31, 1963 AND 1964

	12-31-63	12-31-64	Increase (Decrease)
CASH			
General Fund	$ 4,262.02	$12,000.08	$ 7,738.06
Medical Journal Fund	(2,803.29)	(12,324.48)	(9,521.19)
Convention Fund	3,465.34	3,763.97	298.63
A.M.A. Dues			
Public Service Fund	(61.60)	(752.29)	(690.69)
Medical Scholarship Fund	25,049.54	22,439.80	(2,609.74)
Total Cash	29,912.01	25,127.08	(4,784.93)
U. S. BONDS (at cost)	31,144.91	18,621.92	(12,522.99)
TOTAL CASH AND BONDS	$61,056.92	$43,749.00	($17,307.92)

THE MONTH IN WASHINGTON

(Continued from Page xxvi)

Supplementary Insurance Section

Eligible: Persons 65 years and older.

Cost to beneficiary: $3.00 a month, first $50 of medical bills covered and 20 per cent of total above $50.

Benefits: Payment to the individual or to the provider of services for: (a) physicians' services, and (b) medical and other health services other than those by a provider of services as defined in the bill;

—Payments to providers of service for: (a) inpatient psychiatric hospital services for up to 60 days during a spell of illness, (b) home health services for up to 100 visits during a calendar year, and (c) medical and other health services furnished by a provider of services or by other under arrangements.

—No payment could be made under this program for any services for which the individual is entitled to have payment made under the King-Anderson section.

Administration: The Secretary of Health, Education and Welfare would have to enter into contracts with carriers to administer the program.

Expanded Kerr-Mills

This program would combine all the vendor medical provisions for the blind, disabled and families with dependent children under a uniform program and matching formula. The federal matching share for cash payments for these needy persons also would be increased; services for maternal and child health, crippled children and the mentally retarded would be expanded; a five-year program of "special project grants" to provide comprehensive health care and services for needy children of school age, or pre-school would be authorized; and present limitations on federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

MILD, CONTINUOUS SEDATION

Solfoton

A Solfoton tablet or capsule at six hour intervals maintains sedation at the threshold of calmness. Usually the patient is not conscious of sedation; only conscious of feeling better. Safe for continuous use.
Each tablet or capsule contains: Phenobarbital, 16 mg. Warning: may be habit-forming. *Bensulfoid, 65 mg. Contra-indications: same as those of 16 mg. phenobarbital.

Dispensed in bottles of 100 and 500 tablets or capsules

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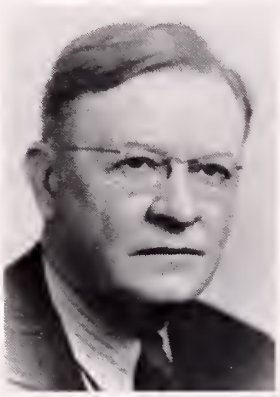
See white section, P.D.R.

Obituaries

WADE HAMPTON ST. CLAIR, M. D.

Dr. Wade Hampton St. Clair, 87, of Bluefield, a Past President of the West Virginia State Medical Association, died on April 10 at the Bluefield Sanitarium in that city.



Wade Hampton St. Clair, M. D.

Doctor St. Clair, who was active for many years in the affairs of organized medicine, died following an illness of three weeks. He had resided at the Bluefield Sanitarium since he suffered a broken hip three years ago.

He was born on April 18, 1877, in Bluestone, Virginia, only a few miles across the state line from his adopted home in West Virginia. He was a son of Alexander St. Clair and Maria Tiffany St. Clair.

He received his academic training at Randolph-Macon Academy and Emory and Henry College, and he received his M. D. degree in 1900 from the University of Virginia School of Medicine. He had postgraduate training in surgery at Polyclinic Hospital in New York City.

In 1902 he became a partner of the late Dr. J. Francke Fox in the practice of medicine and surgery in Bluefield and was a prime mover in the development of the Bluefield Sanitarium.

He was an honorary life member of the Mercer County Medical Society, West Virginia State Medical Association and American Medical Association. He also was a member of the American College of Surgeons and the International College of Surgeons.

Doctor St. Clair served a term as President of his local society and was elected President of the State Medical Association in 1946.

He was preceded in death by his wife, Mrs. Elizabeth Armstrong St. Clair. Two sons were born to Dr. and Mrs. St. Clair. One, Dr. W. Hampton St. Clair, Jr., is engaged in the practice of surgery in Bluefield. The other, Dr. Alexander St. Clair, was a flight surgeon in the United States Army and, in 1943, was lost in a flight from India to China.

He also is survived by one sister, Mrs. Maria Haley of Tazewell, Virginia; four brothers, Glen St. Clair and Roy St. Clair, both of Tazewell, Alex St. Clair of Bluefield, Virginia, and Otis St. Clair of Welch; and four granddaughters.

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Orthopedic Hospital for the treatment of all types of crippling conditions.

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JOSEPH EDWARD RUCKER, M. D.

Dr. Joseph Edward Rucker, 64, of Roanoke, Virginia, died on April 12 at his home in that city.

Doctor Rucker practiced in Charleston for more than 25 years before joining the staff of the Veterans Administration Hospital in Roanoke in 1954.

He was born on October 18, 1901, in Bedford County, Virginia. He was graduated from Randolph-Macon College and received his M. D. degree in 1925 from the Medical College of Virginia. He interned and served a residency at the Medical College of Virginia Hospitals, 1925-29.

He was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

Besides his widow, he is survived by a son, Joseph E. Rucker, Jr., of Roanoke; a daughter, Mrs. Charles Sampson of the Philippines; and one grandchild.

The Most Important Research Animal

Even in the absence of formal experimentation, every doctor who gives a drug, prescribes a procedure or diet for his patient is engaged in an experiment for he observes the result, modifies the dose or procedure as needed, each patient being a unique individual, whose responses will vary from every other patient. Not less research but more research is needed on the most important of all animals—man.—Louis H. Nahum, M. D., in Connecticut Medicine.

County Societies

CABELL

Dr. William Cushard of Washington, D. C., was the guest speaker at the regular monthly meeting of the Cabell County Medical Society at the Uptowner Inn in Huntington on March 11.

Doctor Cushard presented an interesting and comprehensive paper on forensic psychiatry. He discussed tests for criminal responsibility and their meanings. The presentation was followed by active discussion by physicians as well as attorneys, who were guests.

The Society approved Dr. Oscar Weaver's application for membership.

Ninety-six members and guests were present at the dinner meeting.—Harold N. Kagan, M. D., Secretary.

* * * *

HARRISON

Dr. Jay M. Arena, Professor of Pediatrics at Duke University, was the speaker at the March meeting of the Harrison County Medical Society in Clarksburg.

Doctor Arena, a native of Harrison County, presented an interesting paper on "Accidental Poisoning in the United States." He is head of the Poison Control Center at Duke University.

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Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Anesthesiology:
G. E. HARTLE, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Broaddus Hospital Resident Staff:
JOSIAH THOMPSON, M. D.
LUIS GUTIERREZ, M. D.

THE MYERS CLINIC
Philippi, West Virginia

FAYETTE

The regular monthly meeting of the Fayette County Medical Society was held at the White Oak Country Club in Oak Hill on April 7. Members of the Auxiliary also attended the dinner meeting.

Guest speakers were Drs. Shoukry L. Francis and Annis M. Behnam who discussed "Recurrent Urinary Infections." A question and answer period followed.

Fifteen members and guests attended the meeting.—W. P. Bittinger, M. D., Secretary.

* * * *

RALEIGH

Dr. A. C. Chandler of Charleston was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society in Beckley on March 18.

Doctor Chandler gave an interesting account of his experiences during a month-long assignment aboard the U.S.S. Hope in South America last year.

"Project Hope" is supported by the People to People Health Foundation, Inc. The U.S.S. Hope is primarily a teaching project, Doctor Chandler explained, but medical personnel on board do treat patients.

When first organized, "Hope" was sent to Saigon and Vietnam, then later to Peru and to Ecuador. Doctor Chandler spent five weeks aboard the ship in Ecuador in early 1964.

Dr. Warren D. Elliott, President of the Society, presided at the dinner meeting.

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JAMES P. THOMAS, M. D.

Orthopedic:
R. R. RAUB, M. D.

Neurosurgery:
E. L. GAGE, M. D.
WM. F. HILLIER, M. D.

Urology:
T. B. BAER, M. D.

Eye, Ear, Nose & Throat:
F. D. WHITE, M. D.
A. J. PAINE, M. D.

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CARL C. BARGER, M. D.
GRADY McRAE, M. D.

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E. W. McCAULEY, M. D.
C. G. THEDIECK, M. D.
CHARLES S. FLYNN, M. D.

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KARL E. WEIER, M. D.
H. F. WARDEN, JR., M. D.
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R. O. ROGERS, JR., M. D.

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DAVID F. BELL, JR., M. D.
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Artie L. Sturgeon, Ph. D.

Morgan E. Scott, M. D.
Edward E. Cale, Jr., M. D.
J. William Giesen, M. D.
Internist (Consultant)

Don Phillips
Administrator

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David M. Wayne, M. D.
Phone: 325-9159

Beckley Mental Health Center
109 E. Main Street, Beckley, W. Va
W. E. Wilkinson, M. D.
Phone: 253-8397

Charleston Mental Health Center
1206 Quarrier St., Charleston, W. Va.
Malcolm G. MacAulay, M. D.
Phone:344-3578

Mental Health Clinic
Professional Building, Wise, Va.
Pierce D. Nelson, M. D.
Phone: 328-2211

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. George A. Curry, Morgantown
President Elect: Mrs. Wilson P. Smith, Huntington
First Vice President: Mrs. Herbert N. Shanes, Grafton
Second Vice President: Mrs. C. J. Holley, Wheeling
Third Vice President: Mrs. J. A. B. Holt, Charleston
Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William R. Rice, Dunbar.

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society entertained members of the Society with a dinner dance in observance of "Doctors Day" at the Clarksburg Country Club on March 20.

More than 60 physicians and wives attended. Mrs. John D. H. Wilson, President of the Auxiliary, made the welcoming remarks and Dr. A. Robert Marks, President of the Society, gave the response.

Mrs. Albin A. Galuszka was named President Elect of the Woman's Auxiliary to the Harrison County Medical Society during a dinner meeting at the Stonewall Jackson Hotel in Clarksburg on April 1.

Other new officers are: Mrs. A. Robert Marks, President; Mrs. Hugh M. Brown, Vice President; Mrs. Phillip W. Hall, Secretary and Mrs. Boylston D. Smith, Treasurer.

Mr. Ralph Woodburn of the Harrison County Council for Retarded Children was the speaker and his subject was "A Day in the Jacobs School for Retarded Children." Mr. Woodburn showed slides which were narrated by a tape recording.—Mrs. Karl A. Dillinger, Publicity Chairman.

* * * *

KANAWHA

Dr. Tracy N. Spencer, Jr., of South Charleston was guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held on April 13.

Doctor Spencer, Chairman of the Committee on Medicine and Religion of the West Virginia State Medical Association, presented a talk on "Healing and Faith."

Mrs. James H. Walker was named President of the Auxiliary for the coming year. Other new officers are: Mrs. Arthur A. Abplanalp, President Elect; Mrs. James H. Getzen, First Vice President; Mrs. Willis D. Garrard, Second Vice President; Mrs. James T. Spencer, Third Vice President; Mrs. George V. Hamrick, Fourth Vice President; Mrs. Harry A. Jackson, Corresponding

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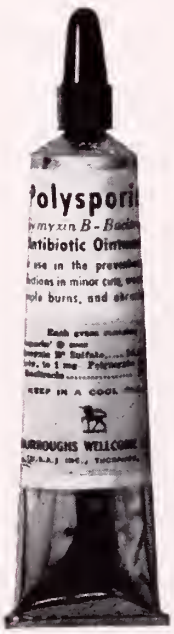

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Secretary; Mrs. David Bachwitt, Recording Secretary, and Mrs. John B. Markey, Treasurer.—Mrs. Arthur A. Abplanalp, Publicity Chairman.

* * * *

McDOWELL

The annual "Doctor's Day" dinner sponsored by the Woman's Auxiliary to the McDowell County Medical Society was held at the Cow Shed in Pineville on April 3.

Dr. and Mrs. Arthur C. Chandler of Charleston were the guest speakers and they presented an interesting and entertaining program. Dr. and Mrs. Chandler traveled to Ecuador in 1964 and they described their experiences aboard the U. S. S. Hope, the hospital training ship which takes to other countries the best America has to offer in the fields of medicine, dentistry and paramedicine.

The speakers said that native doctors were trained in almost all fields of medicine and during the ship's stay in Ecuador more than one million inoculations were given in addition to major surgery, treatment of injuries and disease, care and diet of individuals and sanitation.

Mrs. A. J. Villani was in charge of arrangements for the dinner and her co-chairman was Mrs. A. A. Carr of War, who welcomed members and their guests. The response on behalf of the Society was presented by Dr. Charles F. McCord.—Mrs. Dante Castrodale.

MONONGALIA

Mrs. George A. Curry, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the speaker at the February meeting of the Woman's Auxiliary to the Monongalia County Medical Society.

Mrs. Curry discussed the doctors' "Eldercare" program and listed its advantages over "Medicare."

"Given the facts, there is no doubt that responsible people would choose the 'Eldercare' program," Mrs. Curry said.

Twenty-eight members attended the dinner meeting at the Red Cellar in Morgantown.—Mrs. Hubert Shaffer, Corresponding Secretary.

PLANT PHYSICIAN

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CLASSIFIED

WANTED—Physician for summer relief work in general and obstetrical practice. June, July, August and possibly September. Well-equipped office with laboratory facilities. Please contact R. DeWitt Peck, M. D., 606 Third Avenue, Montgomery, W. Va.

FOR SALE—General surgery practice with some general practice in Southern West Virginia. Population area 250,000. Equipment and other contents of office included in sale, as well as patients' records. Excellent income and easy financial terms can be arranged. Available immediately. Write JAH, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Surgeon to join medical group in Southern Ohio community. Excellent clinic facilities, laboratory with registered technicians, x-ray with radiologist and registered technicians, open staff hospital. Excellent starting salary with increments and fringe benefits and early partnership without financial investment necessary. Write AOB, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—General practitioner, pediatrician, internist and board certified surgeon for community on Ohio River. New 40-bed hospital in industrial community. Write RAO, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

GENERAL PRACTITIONER—Urgent need and excellent opportunity for general practitioner. Solo practice or association with established young GP in Berkeley Springs, W. Va. A clean, progressive, small town within easy driving distance of Washington, Baltimore and Winchester. 60-bed modern hospital. Office space, housing and financial help available. Above average income. Contact C. A. Burgess, M. D., 1090 Fairfax Street, or Robert L. Hale, War Memorial Hospital, Berkeley Springs, W. Va.

WANTED—General practitioner for small community and large surrounding farming area—near coal mines. Good roads and modern conveniences. Retired physician with fifty years experience in general practice and the citizens are interested in helping a physician and believe that the locality offers many advantages. Contact Dr. A. O. Kelly, Wallace, W. Va. Phone 796-3910.

WANTED—Internist urgently needed in a growing northeastern West Virginia community; drawing area is approximately 23,000; modern hospital with excellent facilities; office space available; guaranteed annual income; centrally located for vast recreational facilities. Write RLH, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

PHYSICIAN WANTED — An experienced general practitioner to add to and work with an established salaried group in metropolitan area. This provides regular hours and minimal night work. Contact Charles E. Staats, M. D., 123 West Washington Street, Charleston, W. Va. 25302.

WANTED—Physician for staff position in medical department of Union Carbide Corporation Chemical Plant with approximately 4,000 employees. Liberal benefits; salary commensurate with experience and qualifications; State license required; age limit 65. Write to E. Q. Hull, M. D., Medical Director, Post Office Box 8004, South Charleston, W. Va. 25303.

WANTED—Two general practitioners to locate in the vicinity of Hundred, W. Va., which includes a large area and good advantages. Write Mrs. Mary Mike, Route 1, Burton, W. Va.

WANTED—General practitioner to locate in West Liberty, W. Va. Located 12 miles from Wheeling. West Liberty is the site of West Liberty State College and six miles from Bethany College. Population approximately 600 plus surrounding territory. There are sites available for doctor's office. Write Mrs. Harold F. Daugherty, Box 62, West Liberty, W. Va. Phone 336-7700.

HOUSE PHYSICIAN WANTED—Opening in a new 42-bed hospital. Salary open and good working conditions. Write CCC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Board eligible OB-GYN specialist; 30 years of age, married and 2 children. Residency training at Philadelphia General Hospital and currently completing service obligation. Available in August, 1965 and interested in association or group practice in West Virginia. Write BMT, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—Physicians needed to take over established practice of deceased physician. Modern office available in community located in Southern West Virginia. Trading population of 75,000. Splendid opportunity for one or more physicians. Contact BLW, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Anesthesiologist desires to locate in West Virginia upon completion of training in June, 1965. Nine years experience in general practice. Foreign graduate and licensed in West Virginia. Write LAC, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—General practitioner for large, modern coal mines in southern West Virginia. A splendid opportunity for an energetic practitioner. Write GAC, The West Virginia Medical Journal, Box 1031, Charleston 24.

WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—General practitioner in Richwood. Citizens of this community are interested in helping physician and believe that the locality can offer an ambitious doctor many advantages. Contact Sr. M. Pia C.M.P., Administrator, Sacred Heart Hospital, Richwood, W. Va.

HOUSE PHYSICIANS WANTED—Two openings in a general hospital with 150 beds. Salary open, commensurate with qualifications of applicant. Interview desired and will reimburse one-way fare for same. Write DOD, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324

WANTED—General practitioner for modern 40-bed accredited hospital. Chief of Staff will offer office space and/or partnership to a qualified and ambitious physician. Growing industrial community of 2500 citizens, with a drawing area of approximately 10,000. Located in the beautiful South Branch of the Potomac—the heartland of West Virginia's recreational area. Write Mr. Robert G. Via, Administrator, Hampshire Memorial Hospital, Romney, W. Va.; or phone collect 737.

The West Virginia Medical Journal

June, 1965 Vol. 61, No. 6

Cryptococcus Meningitis

(Report of a Case With Successful Treatment)

William F. Hillier, Jr., M. D., and James R. Shanklin, M. D.

Cases of cryptococcus meningitis are sufficiently unusual in West Virginia that the report of a case in which the patient was treated and cured seems worthwhile.

Case Report

H. J., a male aged 51 years, was seen initially at another hospital and the history obtained was that on March 7, 1962, he sustained an injury to the right side of his head just above the ear, from a drill which kicked and hit him in the head. He was dazed at the time, complained of severe headache, and apparently lost consciousness. Since that time he had had rather frequent headaches which were of a generalized nature. He stated that he had one headache a week and that this was usually relieved by aspirin. One week before admission to the hospital (April 23, 1962), a severe headache developed, with dizziness and a feeling of weakness, and he complained of hurting all over his body and had to leave his work in the mines. The headache had continued almost steadily since that time and had increased in severity. At the time of admission, the headache was located in the forehead. Three days before admission, severe sweating, chills and fever developed, with a persistent headache. He noted his vision failing somewhat but told the attending physician that this had been going on for several months. He indicated also that there had been a decrease in his hearing for the previous year but that this had been worse the day or so before admission to the hospital.

The significant background history reveals that the patient lives in the country and claims to have been in excellent health his entire life and had never been admitted to a hospital. He indicated that he had had asthma since the age of five and had had pneumonia in the past but that this was treated at home with satisfactory results. He has worked in the mines all of his life. He has chickens and works with them a good deal. He has a chicken house which is quite dusty and he is in there once or twice a day. The family has a dog and other domestic animals about the house. There are an outside toilet and an outside well.

On examination, the patient was a thin, well developed white male who appeared to be in pain and was sweating profusely. He complained of violent headache.

Blood pressure 120/80. Pulse 90 and regular. Temperature 101 by mouth.

Positive findings were as follows:

Eyes: There was congestion of the conjunctivae. The pupils were round, regular and equal, and reacted equally to light and accommodation. There was no papilledema and no retinal hemorrhages or exudate. There was some AV nicking. Extra-ocular movements were normal. There was no nystagmus.

Examination of the mouth, nose, throat, lungs, abdomen and extremities were normal.

The Authors

- **William F. Hillier, Jr., M. D., Department of Neurosurgery, Bluefield Sanitarium Clinic, Bluefield, W. Va.**
- **James R. Shanklin, M. D., Department of Internal Medicine, Bluefield Sanitarium Clinic, Bluefield, W. Va.**

Submitted to the Publication Committee, November 10, 1964.

Neurological examination revealed hyperactive deep tendon reflexes in the lower extremities but equal bilaterally. Coordination normal. Vibratory sense normal. Gait normal.

Cranial nerves were normal. Plantar responses were normal. Hoffmann's sign was absent. There was no muscle weakness.

It was the opinion of the attending physician that the differential diagnosis was between (1) meningitis of a bacterial, viral or fungous nature and (2) an expanding intracranial lesion such as a tumor or possible subdural hematoma.

Laboratory studies revealed a blood count of 10,850, with 80 per cent segmented cells, 29 per cent lymphocytes. Urinalyses were normal. A lumbar puncture was done on the day following admission. The fluid was crystal clear—a total of 15 cells predominately lymphocytes. Spinal fluid protein was 50 mg. per cent; sugar 73 mg. per cent. Sedimentation rate was 20 mm. in 1 hour, uncorrected. Stool examination was normal. A repeat spinal puncture three days after admission revealed an initial pressure of 110; a final pressure of 100; 170 cells; 80 lymphocytes; 20 per cent polymorphonuclear; sugar 49 mg. per cent; protein 87 mg. per cent. Skin tests for blastomycosis, histoplasmosis, coccidioidomycosis were all negative. Several cultures of the spinal fluid were reported as negative. The spinal fluid serology was negative. Two weeks after admission to the other institution the spinal puncture was repeated, revealing 313 cells, 84 lymphocytes, 16 per cent Polys. A tuberculin skin test was negative to both first and second strength. Febrile agglutination tests were normal. A fourth lumbar puncture revealed a cell count of 180, 97 per cent lymphocytes, 3 per cent polymorphonuclear, sugar 57 mg. per cent and protein 87 mg. per cent.

Cultures were sent to the state laboratory and these were reported negative for fungi. Further, complement fixation tests for pulmonary mycoses were reported as negative. Culture for tuberculosis was negative. Spinal fluid culture for tuberculosis was negative (Table 2).

Table 2

Grundy Hospital—3-22-62—4-5-62

PRESSURE	RBC	WBC	POLYS	LYMPHS	PROTEIN	SUGAR	CHLORIDE	PANDY
IP. 145								
FP. 110		15	1	14	50 mg. %	73 mg. %		
IP. 110								
FP. 100		170	98	72	87 mg. %	49 mg. %		
		313	63	250				
		180	30	150	87 mg. %	57 mg. %		

The patient was discharged from that institution with the diagnosis of severe aseptic viral meningitis.

On April 21, 1963, he was admitted to Bluefield Sanitarium on the service of J. R. S. for medical observation and treatment because of the long-standing history of headache accompanied by nausea and vomiting. Several days previously, severe nausea and vomiting had developed.

On examination, there was slight tenderness over the right temporal area. There appeared to be some haziness, on fundoscopic examination, in the superior temporal area bilaterally. The retinal veins were full and distended. The other cranial nerves, motor and sensory systems, deep tendon reflexes, and abdominal reflexes were normal. The Babinski sign was present on the right; on the left, questionably present.

It was thought that the patient had a chronic subdural hematoma and on April 29 bilateral burr holes were made. The dura on the right seemed somewhat full and tense. On the left, it appeared normal. A ventricular needle was inserted into the right lateral ventricle and 50 cc.

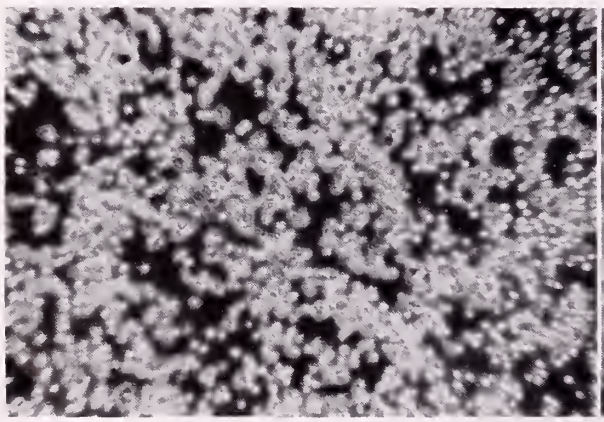

Figure 1. Torula (Phase 2500X).

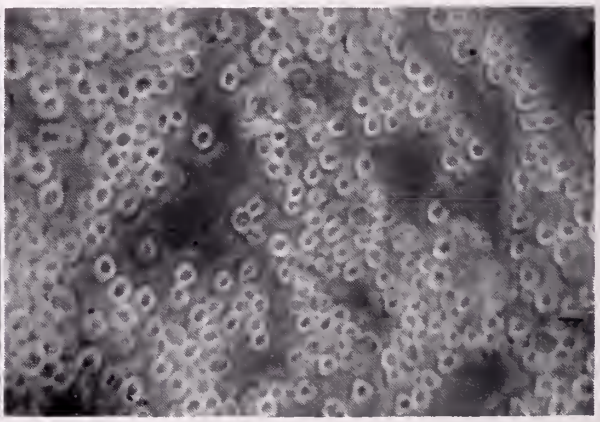

Figure 2. Torula (Phase 6250X).

of clear ventricular fluid was removed. A ventricular needle was inserted into the left lateral ventricle and 16 cc. of slightly cloudy xanthochromic fluid was removed. Air was injected into the lateral ventricles and a ventriculogram revealed all the ventricles to be slightly distended but there was no distortion nor shift in the ventricular system.

The plain skull and chest x-rays were normal.

With these findings there was nothing to suggest the existence of subdural or intracranial hemorrhage nor of a neoplasm. The ventricular fluid from the left side revealed 247 mg. per cent protein, with a 4 plus Pandy test.

The patient was active following surgery but complained of a great deal of headache, vomited on occasion, and four days after the ventriculogram a spinal puncture revealed pressure of more than 600 mm. of water. The fluid was xanthochromic, protein was 195 mg. per cent, with 95 lymphocytes, 5 polymorphonuclear, sugar 14 mg. per cent and a Pandy of 4 plus. The smear and wet preparation of the spinal fluid revealed budding organisms identified as Torula (Cryptococcus neoformans) (Figures 1 and 2).

Treatment was then undertaken with amphotericin B (Fungizone-Squibb) and was a combination of intrathecal and intravenous Fungizone. This was carried out from May 8, 1963 to July 4, 1963. Initially the intrathecal medication was given every other day and the intravenous every day. On May 14, however, there was an alarming rise in the blood urea nitrogen (124 mg. per cent). The intravenous therapy was then discontinued until May 18, and the values of the blood urea nitrogen were as follows:

Date	*Blood Urea Nitrogen*
May 15	124 mg. per cent
May 16	84 mg. per cent
May 17	95 mg. per cent
May 19	45 mg. per cent
May 21	29 mg. per cent

It was felt by the attending physician that continuation of treatment was imperative. The patient's urinary output remained satisfactory and treatment was resumed May 14th, the medication then being given every three days until July 4. Intrathecal therapy was given from May 8 through June 24 and a total of 11 intrathecal injections of Fungizone used. The total amount of drug given intrathecally was 9.5 mg., the total amount given intravenously 1200 mg.

In the accompanying tables it will be seen that the smears and cultures for Torula were carried out from the initially reported culture on May 6 through August 5 (Tables 1 and 3).

The patient's clinical course was exceedingly rocky and unstable. He complained of a great deal of headache initially, with nausea and vomiting. By May 7 he was very restless and negativistic. His speech was thick and slurred and there appeared to be a left central facial paralysis. There was slow improvement and by May 10 he appeared to understand the spoken word considerably better and his speech seemed slightly improved. By May 16, he was more alert and was speaking a few simple words. Along with the elevation of the blood urea nitrogen noted above, he had also a good deal of nausea and vomiting caused, in our opinion, by the Fungizone. By May 29, he was more alert, his speech progressively improving, and by June 23 it was possible for him to be up and about. He was finally discharged from the hospital on July

Table 1

Cerebrospinal Fluid (4-25-63 thru 8-5-63)

DATE	RBC	WBC	POLYS	LYMPHS	PROTEIN	SUGAR	CHLORIDE	PANDY
4-25	8	13			247.5			4+
5-4		30	5	25	195.5	14		4+
5-6	20	63	2	61	187.2	16	107	4+
5-7		51	5	46	133.1	—10	107	4+
5-8		18	1	17	141.0	13	113	4+
5-10	1000	345	339	6	170.6	72	113	4+
5-14	10	72	29	43	239.2	—10	107	4+
5-17	3	31	27	4	201.8	14	118	4+
5-19	0	13	0	13	141.0	24	110	4+
5-21	0	22	1	21	144.3	—10	114	4+
5-24	0	11	0	11	139.4	—10	113	4+
5-28	0	8	0	8	147.7			4+
6-3	20	14	0	14	144.5	13		4+
6-10	10	10	0	10	121.6	19	110	4+
6-24	0	23	2	21	166.4	25	114	4+
8-5	8	23	13	10	187.2	31	120	4+
	Normal 0 cu. mm.	Normal 1-4 cu. mm.			Normal 20-45 mg. %	Normal 40-50 mg. %	Normal 118-128 meq. L	

Table 3

DATE	SMEARS FOR FUNGI	CULTURES FOR FUNGI
5-6-63	Budding organisms present (Torula)	
5-17-63	Budding organisms present	Budding organisms—Cryptococcus neoformans (Torula)
5-21-63	Rare budding organisms	
5-29-63	Budding organisms present	
6-4-63		Budding organisms—Cryptococcus neoformans (Torula)
6-10-63		Very rare budding organisms—Cryptococcus neoformans (Torula)
6-17-63	None	None
6-24-63		None
6-25-63	None	
6-27-63		None
8-5-63	None	None

6, 1963, afebrile, with negative spinal fluid cultures and negative smears for C neoformans.

This patient was again admitted to Bluefield Sanitarium on August 2, 1963, and discharged August 5. The history given to J. R. S. was that he worked in his garden and became overheated and fainted, so that he was promptly brought back to the hospital. A lumbar puncture was repeated and again smears for Torula were negative. The spinal fluid findings are noted in the accompanying table.

Treatment is Specific

The treatment of Torula (C. neoformans) meningitis is with the drug amphotericin B, an antifungal antibiotic derived from Streptomyces nodosus. It is marketed by the Squibb Company under the name of Fungizone, for infusion. Fungizone is supplied as a lyophilized powder in vials containing 50 mg. amphotericin B, 41 mg. sodium desoxycholate, and as buffers, 10 mg. of disodium phosphate, and 0.89 mg. monosodium phosphate. The drug comes as a yellow powder. The preparation is made by adding 10 cc. of sterile water for injection, USP, without a bacteriostatic agent, to the vial of Fungizone, and agitating it vigorously until the solution is clear. Further dilution is then carried out with 5 per cent dextrose in water. If there is any evidence of precipitation or the presence of any foreign matter, Fungizone concentrate and solutions for infusion should be discarded. Therapy should be started at 0.25 mg. per kilogram of body weight and gradually increased to 1.0 mg. or up to 1.5 mg. per kilogram of body weight, but under no circumstances should the total daily dosage exceed 1.5 mg. per kilogram of body weight.

The intrathecal preparation was prepared in essentially the same fashion as the intravenous preparation, then 0.5 mg. of the Fungizone solution was diluted in 20 to 30 cc. of cerebrospinal fluid. The medication was then given intrathecally, 1 or 2 cc., then aspirating further spinal fluid for more dilution and again injecting 1 or 2 cc. until the entire dosage had been given. The intrathecal preparation was well tolerated.

The intravenous medication was given as noted above, markedly diluted in 1000 cc. of 5 per cent dextrose in water.

In addition to the Fungizone 50 mg., heparin 10 mg. and benadryl 20 mg. were given in each infusion in an effort to reduce the danger from thrombophlebitis and severe allergic side reaction. On one or two occasions Solu-Cortef 100 mg. was used and again on several occasions Depro-Medrol 1 cc. was given intramuscularly.

Side Effects.—The most commonly noted side effects from amphotericin B (Fungizone) are the following:

1. Transient anorexia.
2. Chills and fever during the first few days of therapy.
3. Headache, nausea and vomiting.
4. Elevation of the blood urea nitrogen and the nonprotein nitrogen.
5. Local thrombophlebitis.

In the case reported, all of the above mentioned side effects were noted. The chills and fever were treated by analgesics and antipyretics. The nausea and vomiting were treated by intravenous fluid and Dramamine. The most serious complication, in the opinion of the authors, was the marked elevation of the blood urea nitrogen. It was most interesting to note, however, that there was no marked reduction in the urinary output at this time. We stopped the intravenous therapy for three or four days and then because of the seriousness of the basic condition, resumed the therapy and from this point on had no further difficulty with the blood urea nitrogen.

Cryptococcus neoformans (Torula Histolytica)

History—Isolated first in Europe by Busse and Buschke in 1894 and by Curtis in 1896. Since the fungus reproduced by the formation of buds or "blastospores," there was some confusion between this infection and the blastomycosis found in the United States, which led to the older designation of cryptococcosis as European blastomycosis.[9]

Mycology.—Cryptococcus neoformans occurs as small, round to oval, budding cells which average 10 microns in diameter. The most characteristic feature of the fungus is the very wide and prominent gelatinous capsule surrounding the organism. The capsule of material is so transparent that it may it be seen in a clear medium such as cerebrospinal fluid. If cryptococcus is suspected, the material should be mixed with India ink and examined microscopically. In such a preparation, the fungus is seen as a small oval cell in the middle of a much larger colorless area, surrounded by the black particles of the area.

The organism grows readily on Sabouraud's medium, both at room temperature and at 37 degrees, and colonies usually appear within 7 to 20 days. The colony is characterized by a mucoid, gelatinous appearance and smears from the colony show budding cells like those found in the tissues. The capsule can be demonstrated by India ink preparations. The pathogenicity of the fungus can be demonstrated by injecting 1

cc. of a cloudy suspension into mice intraperitoneally. The animals succumb within 3 weeks. The fungus can be demonstrated by smears of the peritoneal fluid or brain.

Epidemiology.—Emmons, in 1950, isolated C. neoformans from barnyard soil and in 1955 found a very frequent saprophytic association with the excreta of pigeons. Strains of C. neoformans from pigeon manure vary in virulence but virulent strains are present in old nests and excreta under roosting sites, in the upper floors of buildings, in cupolas and towers, on window ledges and similar locations in cities, and in stables and haymows of barns in rural areas.[7]

Not Contagious

Cryptococcosis is not contagious and virulent strains of C. neoformans cannot be isolated from the skin mucosa and feces of man with sufficient frequency to support the concept of an endogenous source of infection. Virulent strains of C. neoformans do grow frequently, if not almost constantly, in accumulation of pigeon droppings and at the present time this is the most abundant source of this pathogenic fungus. It is reasonable to assume that exposure to pigeon excreta is the most significant and important exposure experienced by man and animals with cryptococcosis. This type of exposure appears to explain adequately the epidemiology of cryptococcosis.

It is not unusual, therefore, to find among workmen who have been dismantling old barns or houses or buildings where there is pigeon excreta on the window ledges, the development of chills, fever, pain in the chest and cough, and in whose cases x-rays of the chest reveal the typical picture of cryptococcosis.

Carton and Mount,[8] in 1951, noted that of a total of 220 cases reviewed at that time, 178 or 81 per cent of patients, exhibited central nervous system involvement and that there was a 2 to 1 predominance of males in the group. Furthermore, the majority of these patients were dead within one year, actually some 85 per cent, and 70 per cent of these within 3 months of onset.

Pathology

There are four types of torulosis:[2]

1. Meningo-encephalitis, with lesions confined to the central nervous system alone.

2. Central nervous system lesions as a part of a more or less generalized torulosis.

3. Visceral torulosis without localization in the central nervous system.

4. Local infections.

The central nervous system lesions may be classified as follows: (a) A purely meningeal form, (b) A perivascular form with small granulomas or cysts, and (c) An embolic form with deeply placed lesions chiefly in the gray matter of the basal ganglia.

Gross Examination.—1. Granulomatous meningitis, most pronounced at the base of the brain, similar in appearance to tuberculous meningitis.

2. Perivascular accumulations of a grayish exudate in the region of the major blood vessels and particularly in the fissure of Sylvius.

3. Glistening, slippery, disseminated, small, tapioca-like prominences 1.25 mm. in diameter. In coronal sections, the brain reveals the characteristic "soapsuds" appearance caused by the formation of small cysts along the blood vessels of the pial septa.

Microscopic Examination.—1. Diffuse leptomeningitis. The pia and arachnoid are markedly thickened and densely infiltrated with endothelial macrophages, lymphocytes, fibroblasts, occasional plasma cells, and a tremendous number of Torula organisms. The latter, which are mixed with cellular infiltrates, are widely distributed throughout the distended meshes of the subarachnoid space. The endothelial cells and lymphocytes make up a large proportion of the leptomeningeal infiltration.

2. Cyst formation in the gray matter. The gray matter of the cerebral cortex and the basal ganglia contains numerous cystic cavities varying in size and shape. The cystic areas, which are sharply demarcated, harbour a large number of encapsulated Torula organisms, phagocytic cells, lymphocytes and detritus. In some of the larger cysts the content of fluid exceeds the cellular elements. Most of the smaller lesions show a definite perivascular arrangement.

3. Granulomatous lesions in the white matter. Scattered throughout the white matter, these granulomatous lesions are composed chiefly of small accumulations of giant cells harbouring Torula organisms surrounded by numerous fibroblasts and lymphocytes.

Summary

A case of cryptococcus meningitis is reported, together with its treatment. The history, mycology, epidemiology and pathology are discussed.

References

1. Littman, M. L., & Zimmermann, L. E.: Cryptococcosis, New York & London, Grune & Stratton, 1956.
2. Scheinker, I. Mark: Neuropathology in Its Clinicopathologic Aspects, Springfield, Illinois, Charles C. Thomas Co., 1947.

3. Appelbaum, E. & Shtokalka, S.: Cryptococcus Meningitis Arrested With Amphotericin B. Ann. Int. Med. 47:346, 1957.
4. Lehan, P. H., Yates, I. L., Beasher, C. A., Larsh, H. W. & Furcolow, M. L.: Experiences With Therapy of Sixty Cases of Deep Mycotic Infections. Dis. Chest 32:597, 1957.
5. Gendel, B. B., Ende, M. & Norman, S. L.: Cryptococcosis. A Review With Special Reference to Apparent Association With Hodgkin's Disease, Am. J. Med. 9:343, 1950.
6. Mosberg, W. H. & Arnold, J. G.: Torulosis of the Central Nervous System. Review of the Literature and Report of Five Cases. Ann. Int. Med. 33:1153. 1950.
7. Mayer, Karl: J.A.M.A. 187:382-383 (Feb.) 1964.
8. Carton, Charles A. & Mount, Lester A.: J. Neurosurg. 8:143-155, 1951.
9. Burton, R. M.: Head Encephalopathy Complicating Torula Infection, The West Virginia Medical Journal 37:212-214, 1941.
10. Fitchett, M. S. & Weidman, F. D.: Generalized Torulosis Associated With Hodgkin's Disease, Arch. Path. 18:225-244, 1934.
11. Goodhart, S. P. & Davison, C.: Torula Infection of the Central Nervous System, Arch. Neurol. & Psychiat. 37:435-438, 1951.
12. Hall, G. W., Hirsch, E. F. & Mock, H.: Torula Hystolitica Meningo-Encephalitis, Arch. Neurol. & Psychiat. 19:689-694, 1908.
13. Mock, M. H. & Moore, M.: Cutaneous Torulosis. Arch. Derm. & Syph. 33:951-962, 1936.
14. Reeves, D. L., Butt, E. M. & Hammock, R. W.: Torula Infection of Lungs and Central Nervous System. Report of Six Cases With Three Autopsies, Arch. Int. Med. 68:57-59, 1941.
15. Rogers, J. B. & Joloma, F.: Torula Meningo-Encephalitis, J.A.M.A. 100:1030-1030, 1933.
16. Swanson, H. S. & Smith, W.: Torula Granuloma Simulating Cerebral Tumor. Report of Two Cases, Arch. Neurol. & Psychiat. 51:426-431, 1944.

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Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, perferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Psychiatry in Morgantown 1964 – Quo Vadis?*

Robert L. Vosburg, M. D.

I was pleased by the request of Dr. Dave Morgan to describe our position and prospects in psychiatry, and I count it an honor to be able to address you tonight.

Although I would like to talk more generally of medical education before the evening is out, I will begin by giving something of a status report on the Department of Psychiatry and its operation at the School of Medicine. We now have four full-time staff members. Each of us has three obligations to the school: to teach, to advance knowledge, to provide service. Our chief emphasis is teaching, yet a surprising amount of service to the community is given as a by-product of this teaching.

Present Program

Unless you have visited us, you may not know our present program. It consists of (1) lecture series in the freshman, sophomore and clerkship years, (2) a junior-senior clerkship extending twelve weeks, during which time the students receive direct supervision in the extended management of psychiatric problems and (3) an intensive diagnostic and consultation service. The purpose of the freshman lectures is to help students understand the impact of medical school upon themselves. Their study of disturbance of personality is begun by looking objectively at themselves. The purpose of the sophomore lectures is to prepare them to speak the language of current day psychiatry in order to communicate with us and their colleagues. The lectures during the clerkship are directed to clinical problems. While with us, they are supervised in small groups where informality and participation by all is the keynote.

We teach the students that all diseases are disorders in the life span of an organism doing its best to make the most out of its environmental niche. We teach, in short, the only theory basic to biology—evolution. Sometimes this helps them to be more charitable toward the man living on relief or the woman living on chronic complaints. We have had over 160 inpatients this year and an equal number last year. The quality of care corresponds favorably to the best medical centers. Our students see some 450 outpatient visits each year. Again the care is of good quality. I take no personal credit for beginning these service programs. The honor belongs to Doctor Plutzky, who has primary responsibility for the inpatient service; to Doctor Johnson, who is responsible for the outpatient service, and to Doctor Goshen, who had the program underway when I arrived here.

*Presented before a meeting of the Monongalia County Medical Society in Morgantown on November 3, 1964.

Submitted to the Publication Committee, November 19, 1964.

The Author

- **Robert L. Vosburg, M. D., Professor and Chairman, Department of Psychiatry, West Virginia University School of Medicine, Morgantown.**

Appalachia

We have another development which I think noteworthy. We have convened a "behavioral science study group" of professors from sociology, economics and social work. We attempt to demonstrate the application of psychiatric knowledge to problems of human behavior.

Thus, our department is actively participating in the very matrix of studies which will lead to important discoveries in rehabilitation. Every year, it is said, automation puts one million men out of work, yet new industries provide only 500,000 new spaces. If we, in our contribution to rehabilitation, can ease this looming social problem, we can be justly proud.

Communications Analysis

We try to keep our students abreast of developments within psychiatry. One of these developments is the study of communication. The following clinical example may show what I mean. A lady was referred to our service the other day because of the threat of suicide. The history revealed a long tale of emotional ups and downs and marital unhappiness. She was given the customary label, by the student, of "manic-depressive" psychosis. I interviewed her before the television camera (another new wrinkle we have). I had been told that she took countless pills and was, in usual medical student jargon, an addict and an old crock. In asking her about the pills (I think they were Librium or Equanil), it turned out that she would take *one* on days that her husband would pay attention to her and

several on days when he would not. In fact, she had more or less *calibrated* their interaction by subtly changing the number of pills she would take (in his presence, of course), in order to let him know how much he made her suffer. She said the pills had no effect at all upon her.

This way of looking at pill taking is called "the study of human communications." It focuses upon the signal systems which evolve between human beings. It avoids such nebulous notions as death wish and such opprobrious terms as drug addict. It tells us how her disease helps her get along with her husband. The student who knows this will understand drug therapy in a new light. From a research viewpoint, the study of communications has the advantage of being observable and applicable to all creatures. In fact, it was anticipated by Charles Darwin, in 1872, who advised that we study psychotic patients, the development of children, animal societies, myths and legends and works of art, if we wanted to find out how humans get along together in their ecological niche. Up to now, we have had to rely pretty heavily on the lowest common denominators such as dirty jokes, symbols, dreams and other denizens of the unconscious, to understand people.

All of what I have described is being accomplished by four full-time persons. We very much need five additional staff members to provide child psychiatry and the other features of a good program, not to mention some way to take an occasional vacation. Recruiting has been difficult, but we do have some hope.

Analytical View

These facts lead me to the broader problems of medical education. Not everything in Morgantown is peaches and cream, as I well know. Let me talk now for awhile about the scene as I see it. I have been told that there is growing town-gown dissension, that the hospital provides inadequate or faulty service, and that my service especially has not fully fulfilled the high hopes held for it by the community. I would like you, for the moment, to assume your professional roles and take these complaints as presenting symptoms of some underlying disturbance. Let us, as we teach our students, recognize such symptoms of disorder, formulate a prognosis, and try to devise and carry out an appropriate plan for dealing with the situation. That is to say, I shall try to practice what I teach. Of course, it must be immediately apparent to you that the simplicity of this teaching aim is deceptive. Even if I were to limit myself strictly to the curriculum in psychiatry, many complex issues would be raised. For example, there is not yet agreement as to what constitutes or reflects psychiatric disorder, there are deep and honest differences of opinion about causative factors, prognosis is multiply determined, and plans for treatment may involve the family, the job, and other difficult-to-manage influences.

I trust that you are less concerned with the particulars of psychiatry than you are with the general problems of medical education and their implications for all of us in Morgantown. It is for this reason that I have chosen to center on psychiatry as one part of the team and to talk to some extent of the problems of the team.

The Disorder

First of all, I think we all recognize that there is a serious disorder in present day medical school teaching. We have observed since World War II a geometric rise in the expenditures by medical schools. Several have grown to have multimillion dollar budgets, while budgets in excess of five million were rare before the war. For all of this expenditure, many believe that there is little noticeable improvement in the graduates. Public dissatisfaction is signalled by the rise in malpractice insurance fees and general agitation for government interference in the medical establishment. It is not that we have not all tried to teach well. As you may know, I am a psychoanalyst. Physicians with this training have identified themselves with teaching and today the chairmen of almost all major departments of psychiatry are analysts. Despite the increased number of hours of psychiatric teaching in the curriculum and the increased number of psychiatrist teachers on the faculties, it is the opinion of psychiatrists in one major New York teaching hospital that the interns show the greatest ignorance of psychiatry. This generalization made of interns coming from top flight schools across the country, I think might be applied here as well. In other words, it is not a selection bias nor observer bias, but a statement of fact. In our day-to-day practice, this ignorance is manifest by defensiveness, timidity, unrealistic requests for consultations and, evidently, hope that the psychiatrist indeed can practice black magic. Attempts have been made to measure the disorder in our professional training in many ways. One interesting study by Eron shows that first year law students are more cynical than first year medical students but, by the fourth year, medical students are more cynical than law students.

The disorder, then, is something in our medical school teaching that affects the idealism of our students, the quality of medical care and the felicity of intraprofessional relationships. My

motive for coming to Morgantown was to treat, within my limitations, this disorder.

Diagnosis

If you agree with me that there is a disturbance in our teaching system, you may expect me to launch into a diagnosis couched in such phrases as "faulty super-ego," "reaction formation," or the like. And indeed I will. But we have learned to place all problems in the woof and warp of the society in which we live. It is necessary to begin there. You are all familiar, I believe, with the trend of the statistics. The population is growing geometrically while the number of people in the medical profession (I include nurses) is virtually a straight line. Moreover, the growth of technical knowledge in all specialties has inevitably thrust upon medical students the need to subspecialize, indeed if only to survive by mastery of some part of the enormously expanding body of scientific knowledge. Abraham Flexner, by the way, in his famous report, anticipated and warned against this development as a product of the growth of scientific techniques. This drive for excellence through specialization is reinforced by urbanization: large metropolitan areas support such services. Reduced to the level of the magazine, *Medical Economics*, this means the bright young man can see that he will work fewer hours and make a higher income if he specializes and lives in a big city. These same magazines, by the way, advertise Buicks and Cadillacs without asking, "where do you wish to go?" The emphasis is upon externals.

Similarly, the nursing profession has been forced to train nurses to be administrators, and the new graduate may well be the charge nurse of a 35-bed unit. Within this short time, she is expected, of course, to have nodding acquaintance with a variety of technical procedures. In view of these facts, it is inevitable that patient care, I mean the "tender-loving-care-and-understanding aspect of care," has diminished. So great is the hiatus between the present population and the number of physicians that one estimate states that if all M. D.'s were now psychiatrists, the need for psychiatric care alone would not be met. I think I hardly need spell out all of the implications of this situation. It means competition for manpower, an inevitable shift in the practice of medicine as we know it, greater government involvement and, to get right down to brass tacks, that you will not get every psychiatric consultation request answered as promptly as you might like.

Despite these well known sociological data, when Dr. Ralph Kaufman reviewed this situation last year for psychiatric educators, he weighted the problems of the student in dealing with the subject matter of psychiatry more heavily than I have done. His points are cogent. He reminds us that the intrapersonal demands of the doctor-patient relationship are enormously threatening to the young doctor. For this reason, psychiatric teachings tend to be avoided or, more correctly, innate sympathies are suppressed. Let me give a personal example. When I joined the staff this winter, I began by living in the hospital, just as I had as an intern 13 years ago. I was immediately assailed by the ever-present appearance of death. Those of you who have not been away from general hospital practice, as I have been for several years, can hardly appreciate the enormous impact of this experience. Suddenly I understood much better the reserve and apparent coldness of the physician and, perhaps, even something more of my own.

Apropos of this, I like Kaufman's interpretation of the Eron study. He quotes Byron's *Don Juan* where it says "'and if I laugh at any mortal thing, 'tis that I may not weep.'" As psychiatrists, we lack the poetry of Byron. We do observe the great defensive systems which all medical students learn to erect against the impact of death and suffering. On psychological tests, medical students show two predominant defenses: repression and isolation. Generally, these character defenses become solidified by the end of the fourth year and may remain for life.

I hope that I haven't slipped hopelessly into jargon here. Let me say what I mean. When the medical student has learned to look at human excrements and see them as curious specimens for laboratory analysis and when he feels a young woman's breast and notes only the consistency of the fat mass, we know he has developed the "professional attitude." This curious capacity to isolate ourselves from ordinary feelings (a capacity not too easily dropped when we go home) is called, in my vocabulary, a "defense." That we can have one attitude toward a woman on the examining table and another toward her in bed is the defense called "isolation." Psychiatrists have defenses too. When one talks about defenses and character structure it is but another way of referring to psychiatric disorder among us. Various studies indicate that 20 to 50 per cent of all medical students have moderately severe psychiatric problems. While I have no statistics, I presume the numbers are similar for practicing physicians. Perhaps this is no more than to say that we are like the general population in respect to incidence of psychiatric disorder. This means, of course, that there is a

need for several well trained psychiatrists to take care of medical school personnel alone. But relatively few seek this help and, as a group, students and physicians (including psychiatrists) are hostile to the idea of getting help for themselves. Were it not for this defense, our load would be impossible.

Well, so much for the disorder and my diagnosis. My job consists of trying to formulate some way of dealing with this problem. The time is ripe for us to ask "*quo vadis?*" You might wonder if I think our department, or psychiatry, believes it can remedy this great, grim situation. Or, to put it in the words that one of the medical students taught me last year: Am I a person urinating in the ocean with the expectation that the tide will rise? I think not. Speaking for psychiatry, our job as teachers consists for the most part in keeping doctors from forgetting they are human beings, in keeping them from thinking of themselves as mere appendages to some complex medical machine. As I have intimated, this is an enormous task, for one must go counter to great personal resistance as well as to the current trend in medical education and to the pressures of population trends. But the game is worth the candle and I think we have some ways to go about it.

In Summary

I can summarize and end quite briefly. To ask where is psychiatry going in Morgantown, one must first ask where is medical education going. There is clearly disorder in our house and great public unrest and demand for better and more and cheaper service. I believe these demands reflect the growing depersonalization of medical care. This is a product of the growth of scientific medical knowledge, the relative fall in the number of physicians and the fear we all have of walking close to death and suffering. We recommend despecialization and decompartmentalization of the teaching program, an aim consistent with the ecology of West Virginia University.

The role of the Department of Psychiatry, therefore, within the larger context of the medical school's, should be that of training physicians to be truly generalists. Our objective, in other words, is to train the nonspecialists to handle psychiatric problems to the same degree that they are trained to handle medical ,surgical, pediatric, or obstetrical problems.

Soon, of course, we hope to be turning out specialists in the field of psychiatry to meet an urgent manpower problem of the State. We have no residents or interns now on our service, but our plans include both specialized psychiatric residencies and the rotation of other residents through the service. Looking realistically at the national scene, it is inevitable that the need will remain only partially fulfilled.

An issue we have not yet explored at any length, but one which is of direct interest to the practicing physician, is that of postgraduate training. We are prepared to react to your suggestions and interests in this area.

Drug Efficacy – Who's to Say?

THE new drug law should be modified by the deletion of F.D.A. responsibility for "efficacy." The final approbation or disapproval of a drug should be in the hands of the medical profession and not the F.D.A. In addition, there are many officials of the F.D.A. who should reassess their relationship to the pharmaceutical industry in the light of the sound philosophy that a successful democracy is more than a form of government; it is a behavior pattern which stems from the "Golden Rule."—John C. Krantz, Jr., Ph.D., in Military Medicine.

Communicative Disorders of Children: Classification and Criteria for Referral

James M. Mullendore, Ph.D.

During the past half-century, a new and independent profession with its membership devoted to the investigation, evaluation and nonmedical treatment of disorders of oral communication has emerged. More than 13,000 such individuals hold membership in the American Speech and Hearing Association, a national organization with headquarters in Washington, D. C., which includes among its functions the certification of the clinical competence of its members, accreditation of training programs, evaluation of clinical facilities, and dissemination of information through its journals.

With one in every 20 school-age children possessing a speech impediment of sufficient severity to justify specialized attention, and with about one-half that number having potentially significant hearing loss, it may be concluded that the need for services is far in excess of the available supply of professionally trained specialists. The services of the profession are not limited to work with children, however, and help for adults with disorders affecting their oral communication such as hearing loss, aphasia, stuttering, and voice disorders is constantly requested and provided.

The work of the speech pathologist and audiologist is closely interrelated with such professions as medicine, dentistry, psychology and education. There is a particularly close and necessary relation with medicine, for up to one-fourth of the speech disorders and most of the hearing losses have an organic etiology. Because the number of individuals engaging in this profession in West Virginia is relatively small, and since the field is not well known to many physicians, the following information is provided to assist in the determination of the need for referrals for consultation concerning the nonmedical aspects of speech and hearing problems. Although this paper is restricted primarily to the disorders of children, there should be no implication that the practice of the profession itself has age limitations.

Normal Development of Speech and Language

Speech and language develop according to a relatively predictable and systematic time sequence. The development involves the individual sounds of speech, vocabulary and sentence structure, and follows approximately the pattern charted in Table 1. A significant deviation in any of the aspects of this pattern may be an indication that a problem exists which might justify diagnostic study.

Children will ordinarily acquire all of the sounds of speech and the ability to use them in connected sequence by the time they are somewhere between five and seven years of age. Their vocabulary and sentence structure will be adequate at this time for the expression of their vital needs and the verbalization of their reactions to their environment. Their speech also should be free from abnormal rhythm patterns or hesitations, and there should be no abnormal quality such as nasality or hoarseness in their voices.

When the developmental pattern is abnormal, however, or when disorders appear, it is important to identify them as early as possible and secure clinical treatment if necessary. Most of the deviations found in children will fall into one of the classifications discussed below.

Disorders Found in Children

Delayed Speech.—Delayed speech is a disorder characterized either by lack of speech or severe retardation in the development of all aspects of it. It provides the speech pathologist with one of his most difficult diagnostic problems because there are many possible causes to be considered, including low intelligence, deafness, aphasia, brain injury, emotional shocks or conflicts, and environmental deficits. Often an interdisciplinary approach is required to obtain information concerning psychological, neurological and other factors involved in the etiology. Frequently the services both of the speech pathologist and the audiologist are required by the presence of audi-

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Submitted to the Publication Committee, November 4, 1964.

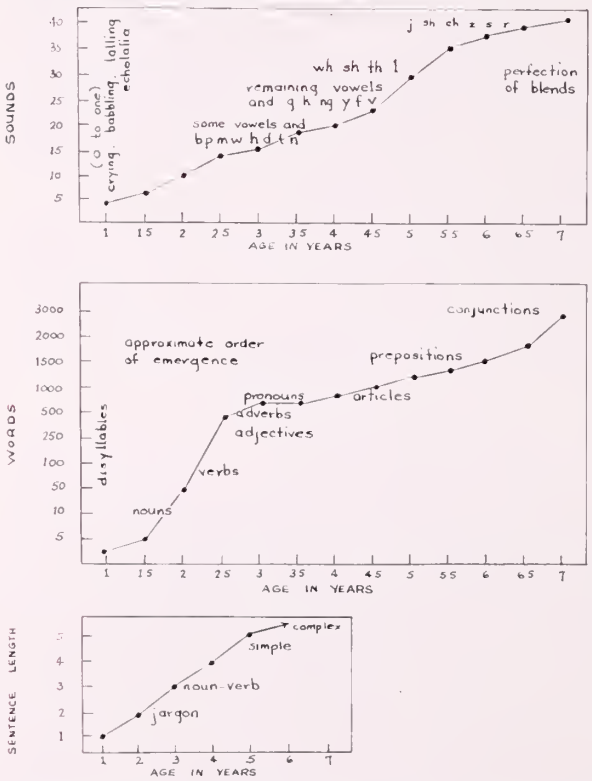
tory problems. Occasionally, a program of experimental therapy must be instituted following the examination to provide continuing evaluation of the child.

Physicians should use the following criteria for referral of such cases to the speech pathologist: (1) Refer when speech has not begun by the third birthday, with no apparent organic cause for the delay. (2) Refer as soon as any identifiable organic disorder is suspected as causal. (3) Refer when the speech development falls behind its normal progress by one and one-half years or more.

Baby Talk (Infantile Perseveration).—Infantile perseveration is a disorder characterized by immaturity and confined mainly to difficulties with individual sounds. Sound substitutions such as *th* for *s* and *w* for *l* and *r*, are typical. It is found more frequently than delayed speech but ordinarily is of functional rather than organic etiology. Organic causation may not be ruled out, however, because of the possible influences of retarded physical development, orofacial injuries, miscellaneous physical anomalies, intellectual or social immaturity, and numerous environmental conditions such as too high or too low parental standards, or over-protection. The child may have a normal vocabulary and adequate ability to use sentences, but may exhibit infantile word substitutions such as "me" for "I" in his speech.

Table 1

The Normal Development of Speech and Language



Note: These standards have been derived from an analysis of the numerous research studies on the development of speech and do not reflect any single source. (James M. Mullendore, Ph. D., West Virginia University; and Helen G. Burr, Ph. D., University of Virginia).

The primary criterion for referral would be to seek the services of the speech pathologist when the development of the individual sounds of speech falls behind the norm by one and one-half years or more. The rationale here is that, with such a delay, the speech defect would interfere with the child's school progress if continued into the school years and would tend to become permanent if uncorrected.

Stuttering.—Stuttering is a speech disorder characterized by a disruption of rhythm and fluency for which there is no apparent physical cause. The observable symptoms of stuttering may range from very mild hesitations or repetitions to gross and generalized spasms with prolonged disruption of speech. There are several identifiable stages of stuttering, the two most significant of which may be defined as follows:

> Primary stuttering: An early stage characterized by easy hesitations and repetitions without struggle or awareness of difficulty, and usually affecting the initial sounds and syllables of words.
>
> Secondary stuttering: A later stage of the disorder in which hesitations and repetitions are accompanied by an awareness of difficulty, together with secondary symptoms such as facial grimaces, body jerks, and other evidence of the stutterer's effort to surmount, avoid, control, or evade the block.

Ordinarily a speech pathologist will not recommend or provide active therapy for the primary stutterer but will provide advice to the parents concerning the problem and its management in the home or school environment. When secondary characteristics have appeared, it is almost always advisable to provide clinical therapy.

A referral to the speech pathologist should be made for primary stuttering not later than six months after the onset of the symptoms. In secondary stuttering the disorder should be referred as soon as identified.

Deafness or Impairment of Hearing with Speech Defect.—Whenever there is an impairment of the auditory mechanism, there may be articulatory defects, voice defects, or a failure of speech to develop. Since an individual with a hearing loss is unable to hear his own speech accurately, he is unable to control its acoustic properties. Moreover, he may be unable to develop a concept of the purpose and use of language. It should be noted that auditory defects may be of many types and characteristics. Most are peripheral but some may be central. Some may have a relatively slight effect upon

speech but others may profoundly affect its development. Usually there are some clues leading a physician to suspect a loss, such as the absence of crying and the parents' reports of the child's failure to hear or comprehend.

When a hearing loss is suspected, an audiological evaluation should be secured as soon as possible to determine both the extent of the loss and the need for remedial procedures. The physician should accompany such a referral with a report of the organic findings concerning the hearing mechanism and background information such as familial history of hearing loss, administration of drugs, and the history of significant high fevers or diseases.

Cleft Palate Speech.—This is an organic disorder usually characterized by articulatory and vocal defects and requiring a team approach for optimal rehabilitation. Ideally, the team should be assembled while the child is still in infancy in order that the specialists as a group may assess the relative importance and sequential order of the required remedial procedures.

Referral to the speech pathologist should be made within the first year of the child's life in order to (1) evaluate the probable effect of the disorder upon the development and acoustic properties of speech, (2) estimate the effects of surgery or prosthesis upon voice and articulation, (3) advise parents on procedures for home instruction and (4) recommend the time and nature of a clinical therapy program. If the child is not encountered until a later age and any deviation in speech is observed, the referral should be made for the purpose of evaluating the problem and determining the need for therapy.

Voice Disorders.—Voice disorders, or dysphonias, are characterized by recognizable and unpleasant differences in the pitch, loudness, or quality of the vocal tone. Possible causes include structural defects of the vocal folds or resonance cavities, imitation, habitual misuse of the speech mechanism, and miscellaneous emotional and physical factors. Such disorders are found only in a very small percentage of children.

There are two major criteria for referral to the speech pathologist in such cases: (1) When the disorder appears to be related to an organic anomaly not subject to routine medical or surgical treatment, consultation should be sought as soon as that relationship has been established. (2) A referral should be made when the disorder persists beyond the fourth birthday in the absence of an apparent cause, or after medical and surgical treatment of the organic cause.

Neuromuscular Involvements Affecting Speech.—Disorders such as cerebral palsy, bulbar polio, muscular dystrophy, and others frequently have accompanying voice and articulatory defects. Here the team approach to rehabilitation may involve the speech pathologist and audiologist for purposes of consultation and therapy. Without elaborating upon the numerous diagnostic problems and therapeutic approaches to such disorders, it is suggested that when such a problem is presented to the physician, he should consider as criterion for referral or consultation that such a course is indicated whenever a speech or hearing defect is present or possible as a consequence of the involvement.

Role of the Speech Pathologist and Audiologist Following Medical Referrals

Referral to a speech pathologist or audiologist does not automatically imply that therapy will be needed or prescribed. Furthermore, it should be noted that these specialists provide their services by referral and not by prescription. While policies of clinics vary, it may be stated that the majority of speech problems are self-referred, while the majority of hearing problems come through medical referrals from otologists or pediatricians.

It also should be observed that some of the most important services of this field are provided in the areas of consultation, guidance and counseling. Normally, the procedure of the speech pathologist or audiologist is to interview the patient or parents, or both, test the speech and language development, obtain additional relevant information where required, and identify and classify the disorder. Characteristically, this is followed by an explanation of the problem to the individual and the parents, together with such recommendations as may be required for the management and correction of the problem. In some cases, such a recommendation may involve only procedures to be conducted by the parents in the home. In other instances, re-examination after an interval of time is recommended to determine the progress without therapy. In still other cases, referral to another clinical discipline may be advised, where additional psychological, medical, or educational information is necessary. Finally, where it appears that a program of clinical speech or hearing therapy might be beneficial, such is prescribed and administered. Routinely the full report is sent to the referring individual or agency.

Because the successful management of disorders of oral communication requires close and effec-

tive cooperation between members of the several professions, speech pathologists and audiologists work constantly to maintain and improve the cooperative relationships between their discipline and the fields of medicine, dentistry and education, and perform their services in accordance with the type of professional and ethical codes characteristic of the medical profession itself.

Information Concerning Referrals to Speech and Hearing Clinicians in West Virginia and Adjacent States

While speech and/or hearing clinicians are not numerous in West Virginia, the resources listed below are available for referrals. Contact the individual named below for information or appointments. Specify whether the problem is speech or hearing, since most clinicians are not certified in both areas and may therefore desire to suggest another specialist.

North and Northern Panhandle

Morgantown. West Virginia University Speech and Hearing Clinics (units on main campus and in Medical Center), James M. Mullendore, Ph.D., Senior Professor and Coordinator of program. Contact Main Campus Clinic.

Wheeling. Society for Crippled Children and Adults, 1316 National Road. Miss Glynda Walker.

Parkersburg. Wood County Society for Crippled Children and Adults, 700 18th Street. Miss Mary Lou Barnes, Coordinator.

Western

Charleston. Kanawha Speech and Hearing Center, Memorial Hospital, 3200 Noyes Avenue S. E., Mr. Jesse Barton, Director.

Huntington. Marshall University Speech and Hearing Clinic. Mrs. Ruth Garrett, Director.

Southern

Bluefield. Bluefield Sanitarium Speech and Hearing Clinic.

Facilities in Adjacent States (Selected examples).

Pennsylvania

Pittsburgh. University of Pittsburgh Speech and Hearing Clinic, Jack Matthews, Ph. D., Director; Department of Audiology (hearing), Eye and Ear Hospital, Leo G. Doerfler, Ph. D., Director; Children's Hospital Speech Clinic, Doris Bradley, Ph. D., Director.

Ohio

Athens. Ohio University Speech and Hearing Clinic, Richard Ham, Ph. D., Director.

Virginia

Roanoke. Easter Seal Speech and Hearing Center, 4841 Williamson Road, Miss Charlene Baddour, Director; and Memorial Hospital Rehabilitation Center, Mrs. B. B. Lubker, Director.

Charlottesville. University of Virginia Speech & Hearing Center, Helen Burr, Ph. D., Director.

In addition, the following public school divisions employ speech therapists who are sometimes available for consultation on speech problems on evenings, weekends and days when school is not in session: Brooke, Greenbrier, Hampshire, Harrison, Jackson, Kanawha, Marion, Marshall, Monongalia, Raleigh, Wayne. Call the local school offices for information.

It also should be noted that a number of the local chapters of the West Virginia Society for Crippled Children and Adults (Easter Seal Society) sponsor summer speech clinical programs for children. Call the local Easter Seal Society president for information.

Wanted: Less Haste in Lawmaking

ALTHOUGH there may be a need for controlling false claims for medical devices, one might well hope that the haste which resulted in the new laws and regulations about drugs will not serve as a pattern for legislation related to physical devices. The drug controls, in many respects, appear to go far beyond what is necessary to ensure reasonable safety. Surely, in the final drafting of bills on medical devices, experts in the industry as well as university researchers should be given full opportunity to make available their knowledge and experience.—Morris Fishbein, M. D., in Medical World News.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 26-28, 1965

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

THE TRIPLE THREAT

PROGRESS in every age results only from the fact that there are some men and women who refuse to believe that what they know is right cannot be done."—Russell W. Davenport.

I had hoped that this month's page could have been written about our appreciation to the Auxiliary for their many efforts in our behalf, about the desperate need for a conference of County Medical Society and Auxiliary Officers and your State Medical Society Officers, to review our mutual problems and to find ways for better communication between these levels.

However, once again, we stand on the brink of socialistic legislation in Congress and we talk again of our needs there.

The Mills Bill, HR 6675, is at this writing in the open hearing stages before the Senate Finance Committee and as the hearings unfold, we learn that this piece of legislation is the worst of socialistic wrapups and that it had a Trojan Horse behind the scenes advising the House Ways and Means Committee, which included not only the social planners in government but the officers and spokesmen of our allied profession in Blue Cross, the American Hospital Association, the American Nurses Association and others. Each day we learn of the implications and threats to the freedom of our profession already in the bill. The move to reinsert pathologists, radiologists, anesthesiologists and physiatrists into the King-Anderson portion of the bill is being pushed by some misguided members of our allied professions. The principle of *compulsory* hospitalization, whether a need does or does not exist, is the crossing of the Rubicon. The tax principle imposed on Social Security, to give not a service but cash benefits plus the introduction of deductibles is the first such bill not using *general* tax funds. The compulsory inclusion of physicians under Social Security is also part of HR 6675. This is historic and yet more obviously socialistic. Let our senators know how *you* feel about this.

A second threat to medicine is becoming more evident in the alleged attack on cancer, stroke and heart diseases with its many centers, which will totally disrupt and take away badly needed manpower from our present medical schools, teaching hospitals, research centers and set up a more elaborate socialistic complex than even the Mills Bill had envisioned. The American Academy of General Practice, and many state and local medical societies have raised their voices to sound the alarm. We need much more study of the implications contained in this piece of legislation before it becomes a reality.

A third threat is the sleeper in the recently passed Appalachia Bill, which includes $41 million to build multi-county demonstration health facilities, including hospital, diagnostic and treatment centers, with funds to run these 100 per cent for two years and 50 per cent for three additional years.

As these ever increasing socialistic threats become more manifest, it becomes more obvious that unity of our profession is our only salvation.

Over these many years, in attempting to meet the demands of our profession, fighting socialistic legislation on state and national levels and with an ever increasing cost spiral our State Medical Association finds it has strained its financial resources beyond its limitation where it now becomes obvious that a dues increase is in order if we are to continue our struggle in these critical times.

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

MEDICARE 1965—HR 6675

The full effect of Medicare 1965—HR 6675—is slowly filtering through to medicine and the public. In the passage of this bill by the House of Representatives it is apparent that organized medicine lost its struggle to maintain those principles of medical practice which have served to give the USA the best medical program in the world. Although the bill still must pass the Senate, all analyses indicate that the Senate will support and perhaps amplify the provisions of HR 6675.

The West Virginia State Medical Association, with the support of almost all its members, waged a vigorous campaign to express disapproval of HR 6675. The bill passed by the overwhelming vote of 313 to 115. This is a rather good indication of the lack of influence that medicine and individual physicians have in Congress concerning a bill that represents a handout to a large segment of organized voters.

As in the case of all welfare bills, this congressional action will be subject to changes in successive sessions at the will or whimsey of its members, so we can anticipate an increase in the projected formula of the tax and wage base. This is the history of the Social Security program. The public cost of this program may be expected to accelerate—but no one these days is concerned with the cost of welfare and wars.

Also included in the omnibus bill passed by the House is a provision which provides compulsory Social Security coverage for self-employed physicians. In 1966 the individual physician will begin the payment of 6.35 per cent of his first $5,600 in annual earnings to the federal government for an ephemeral pension at 65, if he chooses to retire at that age, or he may continue to pay into the kitty until he reaches 72 years. He still cannot realize any return until he limits his income to $1,200 a year. For a vast majority of physicians, such yearly taxes will be dedicated to the common cause. With similar deductions to private insurance interests, he could achieve surety and more income.

HR 6675 now excludes the costs of pathology, radiology, anesthesiology and physical medicine but it is indicated that an amendment will be proposed in the Senate to include such costs under the heading of "reasonable costs." This amendment will have the full support of various hospital groups. At this time hospital costs include many of these professional services and this gives additional income and an inflated level to hospital charges.

Most hospital physicians prefer that their services be conducted on a private professional

basis. The convenience to the physician of billing for these services in the hospital account is minimal, and long ago these private services should have been removed from the hospital bill.

If HR 6675 is enlarged and amended to envelop the services of a large segment of medical practitioners, then we have taken another big jump toward socialism and we can shout to the National Health Service of Great Britain—"Here we come!"

The following is an excerpt from the testimony of the American Hospital Association before the Senate Finance Committee on May 4, 1965:

> "We strongly believe that if the deletion of specialists' services for aged beneficiaries remains in this Legislation, it will certainly lead to the extension of the practice to all other patients. In various ways the needs of the public and the efforts to provide the best possible patient care at the lowest possible cost is tending toward the increased concentration of a wide variety of highly skilled and trained specialists working full time in hospital centers. The separation of physician specialists as proposed in this legislation is totally contrary to the whole direction of health care practice in our nation."

This a new philosophy in medicine: That the practice of medicine will become an appendage to hospital administration. The future will include only hospital centers, and physicians will be integrated into hospital service. We ask: "Is this the proper direction for medical practice in the United States?"

We believe that all sections and specialties of medicine, even though their practice is confined to the hospital, are integral components of the practice of medicine and are not a part of any hospital program.

In this State we have learned that a majority of specialists prefer to keep their medical practices separated from hospital administration. Officers of the Sections on Radiology, Pathology and Anesthesiology have informed the State Medical Association that they oppose the declaration of the American Hospital Association.

This must indicate that physicians, although their activities are mostly within the hospital, prefer to remain in medicine and not become a part of hospital practice under non-professional direction. Under the Douglas amendment, 15 per cent of our physicians would become salaried hospital employees rather than independent practitioners. Fifteen per cent of the practicing physicians would be subject to all the rules and regulations of the Secretary of Health, Education and Welfare concerning hospitals participating in the program.

Dr. Edwin L. Crosby, vice president of the American Hospital Association, has stated that the exclusion of these services would retard the growth of the modern hospital. But the doctor does not state that the inclusion of professional services within his hospital program would subordinate 15 per cent of all physicians to hospital management and that this is contrary to the Principles of Medical Ethics of the American Medical Association which states:

> "A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine—in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

The exclusion of professional services in Medicare is not a major problem to physicians, government, insurance, nor to hospitals. It is only the latter that is doing the "squawking."

All physicians, especially those who practice within hospitals but prefer to retain their identity in medicine, are urged to inform their Congressional representatives that they resent this hospital-supported amendment that will relegate them to the dependent status of hospital employees.

Loan-Guarantee Program Successful

The American Medical Association's loan-guarantee program is providing financial assistance to one of every six American medical students, interns and residents.

Since the Education and Research Foundation's program was started three years ago, more than 19,000 loans amounting to more than $27.6 million have been guaranteed. Medical students may borrow $400 to $1,500 annually for seven years with 10 years to repay.

The Foundation has raised $2,472,000 as a guarantee fund for the loans. Each dollar guarantees $12.50 in bank loans through a cooperative program with three banks, providing a credit potential of more than $30 million. Loans are being made at a rate of 600 a month.

Dr. Daymond M. McKeown of Coos Bay, Oregon, President of the Foundation, said additional contributions are needed to keep the program on a sound financial basis.

It is expected the program will become self-sustaining in four to five years, Doctor McKeown said. New loans then will be possible through the repayment of old loans.

Borrowers already have repaid 384 loans and are making payments on 2,167 others.

GENERAL NEWS

Plans Nearing Completion for Annual Meeting at The Greenbrier

Two prominent physicians from the neighboring state of Ohio have accepted invitations to appear as guest speakers at the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, said that Dr. Leon Schiff of Cincinnati and Dr. Thomas E. Shaffer of Columbus will present papers during the three-day meeting.

Leon Schiff, M. D.

Thomas E. Shaffer, M. D.

Doctor Schiff, who is Professor of Medicine at the University of Cincinnati College of Medicine, will appear as a speaker at the second general session on Friday morning, August 27. His subject will be "The Differential Diagnosis of Jaundice."

Doctor Schiff also will present a paper on "The Use of Steroids in Liver Diseases" before a meeting of the Section on Internal Medicine on Friday afternoon.

A native of Riga, Latvia, Doctor Schiff was graduated from the University of Cincinnati and received his M. D. degree in 1924 from the University of Cincinnati College of Medicine. He also received a Ph.D. degree in 1929 from the same college. He served an internship and had residency training at Cincinnati General Hospital and also had postgraduate training in Germany.

He joined the faculty of the University of Cincinnati College of Medicine in 1930 and was named Professor of Medicine in 1958. He also has served since 1938 as Director of the Gastric Laboratory at Cincinnati General Hospital.

He is the author of several books, including the "*Differential Diagnosis of Jaundice*" and "*Clinical Approach to Jaundice.*" He also is the author of numerous papers dealing with liver and digestive tract diseases.

Doctor Schiff is a Fellow of the American College of Physicians and a Past President of the American Association for the Study of Liver Diseases.

Thomas E. Shaffer, M. D.

Dr. Thomas E. Shaffer, who is Professor of Pediatrics and Preventive Medicine at the Ohio State University College of Medicine, will appear as a speaker at the first general session on Thursday morning, August 26.

Doctor Shaffer, who also serves as team physician at Ohio State University, will present a paper on "The Adolescent Athlete."

A native of Asaph, Pennsylvania, Doctor Shaffer was graduated from Cornell University and received his M. D. degree in 1932 from Cornell University Medical College.

Doctor Shaffer served as an Instructor in Pediatrics at the Yale University School of Medicine from 1936 to 1942 and during that period was also engaged in private practice in New Haven, Connecticut. He served for four years as a Major in the Medical Corps of the U. S. Army.

He joined the faculty at Ohio State in 1946 and has been there ever since except for a one-year period during which he served as Professor of Preventive Pediatrics at Temple University School of Medicine. He also served for four years as Director of Medical Services of the State of Ohio Juvenile Diagnostic Center before returning to full-time duties at Ohio State last August.

Doctor Shaffer is a member of the AMA Committee on the Medical Aspects of Sports and in 1964 was awarded the William G. Anderson Award by the American Association of Health, Physical Education and Recreation "in recognition of meritorious service to the Profession of Health, Physical Education and Recreation."

He is certified by the American Board of Pediatrics and is a member of the American Pediatric Society and the American Academy of Pediatrics. He is currently serving as Chairman of the Ohio Chapter of the American Academy of Pediatrics.

Drs. Appel and Judd Honor Guests

The Program Committee announced previously that Dr. James Z. Appel had accepted an invitation to be the guest speaker before the first session of the House of Delegates on Wednesday afternoon, August 25, the day preceding the formal opening of the meeting.

The Pennsylvania physician will be installed as President of the AMA during the Annual Convention in New York City later this month.

Another honor guest will be Dr. Walter H. Judd, former medical missionary and Congressman from Minnesota, who will appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 26.

Other physicians and surgeons who will appear as speakers are as follows:

Dr. R. Gordon Douglas of New York City, Professor of Obstetrics and Gynecology at Cornell University Medical College; Dr. Cornelius E. Sedgwick, a member of the staff of Lahey Clinic in Boston; and Dr. William G. Thurman, Professor and Chairman of the Department of Pediatrics at the University of Virginia School of Medicine.

Sessions of the House of Delegates

There will be two sessions of the House of Delegates during the meeting. The first session will be held on Wednesday afternoon, August 25, the day preceding the formal opening of the convention. Doctor Appel will be the speaker.

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second session of the House of Delegates on Saturday afternoon, August 28.

AMA Nursing Program

The American Medical Association's Committee on Nursing will present a program in New York on June 22 during the 114th Annual Convention of the AMA.

The afternoon program will be held at the Barbizon Hotel as part of the convention's scientific program.

Dr. Barbara Bates, Assistant Professor of Medicine at the University of Kentucky, and Dr Luther P. Christman, Associate Professor of Nursing at the University of Michigan, will present papers on "Nurse-Physician Communications in the Hospital."

Re-Registration Deadline June 30

Application forms for re-registration to practice medicine were mailed recently by the Medical Licensing Board to all physicians currently licensed to practice in the State of West Virginia.

The biennial fee for the re-registration of physicians was increased from $2 to $5 by the Legislature during the 1965 session. The deadline for payment of the re-registration fee is June 30.

Physicians who have not received the application form should contact the Medical Licensing Board of West Virginia, State Office Building, 1800 Washington Street, East, Charleston, W. Va. 25305.

Chronic Diseases Worst Killers In W. Va. Last Year

Chronic diseases accounted for eight in ten deaths in West Virginia during 1964.

State Health Director N. H. Dyer in a recent issue of the "State of the State's Health," discussed a report giving the provisional figures on births and deaths in 1964, recently released by the State Department of Health's Division of Vital Statistics.

He noted that heart disease, cancer and strokes were responsible for 78 per cent of the total deaths. Diseases of the heart and circulatory system represented the cause of death in two of three cases.

Doctor Dyer related that the provisional figures on major causes of death in the state during 1964 showed the leading cause to be heart disease, accounting for 6,993 deaths; second, malignant neoplasms, 2,674 deaths; third, vascular lesions affecting central nervous system, 2,021 deaths; fourth, accidents, 1,017 deaths; fifth, pneumonia and influenza, 603 deaths.

The sixth leading cause of death was diseases of early infancy with 603 deaths; seventh, general arteriosclerosis with 317 deaths; eighth, diabetes mellitus with 287 deaths; ninth, congenital malformations with 173 deaths; tenth, nephritis and nephrosis with 135 deaths; eleventh, tuberculosis with 121 deaths.

He pointed out that there were 16,808 male births or 51.8 per cent of the total of 32,436 in 1964. Physicians delivered 99.3 per cent of the newborns and 98.4 per cent of all births were in hospitals. Some 1,876 illegitimate births were recorded, about 7 per cent of the total.

Wirt County registered the highest birth rate with 22.3 per 1,000 population. Wood County had a rate of 21.8; Calhoun and Wetzel, 21.5; Lincoln, 21.2. Hardy and Pendleton had the lowest birth rate with 9.0 per 1,000 persons.

Kanawha County listed 4,687 births, the largest number, with a rate of 18.9. Cabell had 2,092 (19.4); Wood, 1,668 (21.8); Harrison, 1,431 (19.3); McDowell, 1,213 (18.8); Raleigh, 1,191 (16.5).

Kanawha County recorded 1,846 deaths; Cabell, 1,161; Harrison, 764; Ohio, 762; Wood, 741; Raleigh, 650.

Doctor Dyer noted that the numbers and rates for some counties given on the provisional report may be revised substantially when the final report is prepared, which will include additional data and interstate corrections for non-resident births and deaths, but the pattern is not likely to change.

Heart Assn. Meeting in October

The annual scientific sessions of the American Heart Association will be held at the Americana Hotel in Miami Beach, Florida, October 15-17. The sessions are held in conjunction with the Association's annual meeting which will continue through October 19.

Dr. Ralph W. Ryan New President Of Oph. & Otol. Acad.

Dr. Ralph W. Ryan of Morgantown was installed as President of the West Virginia Academy of Ophthalmology and Otolaryngology during the 18th annual meeting of that organization at The Greenbrier in White Sulphur Springs, April 18-21. He succeeds Dr. R. Alan Fawcett of Wheeling.

Other new officers are as follows:

Dr. Worthy W. McKinney of Beckley, President Elect; Dr. James Elliott Blaydes, Jr., of Bluefield, Secretary-Treasurer; Drs. William C. Morgan, Jr., of Charleston, Alfred J. Magee of Charleston and Edward Shupala of Parkersburg, Directors; and Drs. James T. Spencer of Charleston, Albert C. Esposito of Huntington and R. Alan Fawcett of Wheeling, members of the Executive Committee.

The scientific program included papers presented by the following guest speakers:

Drs. David F. Austin of Chicago; Edwin W. Cocke, Jr., of Memphis, Tennessee; Arthur G. DeVoe of New York; David A. Dolowitz of Salt Lake City; Philip M. Lewis of Memphis, and Nathan S. Schlezinger of Philadelphia.

Speakers at the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at The Greenbrier included, left to right: Drs. Philip M. Lewis, Professor and Chairman of the Division of Ophthalmology at the University of Tennessee; Dr. Arthur G. DeVoe, Director of Eye Service, Institute of Ophthalmology, Presbyterian Hospital, New York; Dr. David F. Austin, Assistant Professor of Otolaryngology at the University of Illinois, and Nathan S. Schlezinger, Chief of Neurology at Wills Eye Hospital, Philadelphia.

Dr. Greco Speaks at Dietetic Meeting

Dr. Ray S. Greco of Weirton was a speaker at the Spring meeting of the West Virginia Dietetic Association at Wilson Lodge, Oglebay Park, Wheeling, May 6-7.

Doctor Greco presented a paper on "Psychological Aspects of Patient Food Service."

Otol. Assembly In Chicago

The annual Otolaryngologic Assembly will be held at the new Illinois Eye and Ear Infirmary at the Medical Center in Chicago, October 30 through November 5.

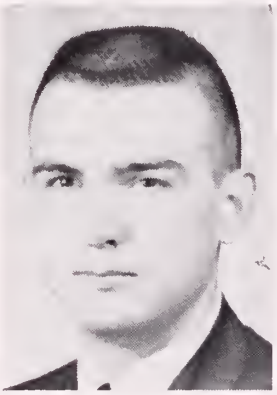
It is designed to bring specialists current information in medical and surgical otorhinolaryngology.

Additional information may be obtained by writing to Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, P. O. Box 6998, Chicago, Illinois 60680.

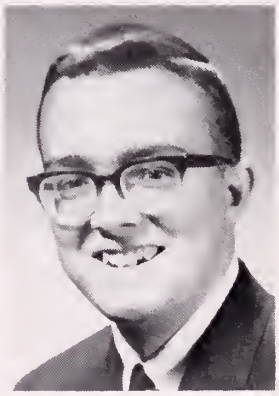
New officers of the West Virginia Academy of Ophthalmology and Otolaryngology are shown after their election April 21 at The Greenbrier, White Sulphur Springs. Left to right are: Dr. J. Elliott Blaydes, Jr., Secretary-Treasurer, Bluefield; Dr. Worthy W. McKinney, President Elect, Beckley; Dr. Ralph W. Ryan, President, Morgantown; Dr. R. Alan Fawcett, Retiring President, Wheeling, and Dr. W. C. Morgan, Jr., Director, of Charleston.

Two 1965 Scholarship Recipients Selected by Committee

Creel S. Cornwell, Jr., of Lost Creek and William L. Mossburg of Morgantown have been selected by the Medical Scholarships Committee of the West Virginia State Medical Association as the 1965 recipients of the four-year scholarship awards to the West Virginia University School of Medicine.



William L. Mossburg



Creel S. Cornwell, Jr.

Announcement of the awards was made by Dr. J. P. McMullen of Wellsburg, the Chairman, following a meeting in Morgantown, April 23-24.

The scholarships, each worth $4,000, are awarded annually to students enrolled in the first-year class at the School of Medicine. The two recipients will accept the awards formally during the 98th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs in August.

Mr. Cornwell, 21, is the son of Mr. and Mrs. Creel S. Cornwell of Lost Creek. He was graduated from Lost Creek High School and had his pre-medical training at West Virginia Wesleyan College.

Mr. Mossburg, 26-year-old son of Mrs. Grace M. Cummins of Westover and the late John A. Mossburg, was graduated from Morgantown High School. He took his undergraduate work at West Virginia University.

The two men will begin their studies in September as freshmen in the WVU School of Medicine. They are the eleventh and twelfth students to receive scholarships under the program inaugurated by the State Medical Association in 1958. The Association awarded one scholarship per year until 1961, and the House of Delegates voted that year to provide an additional annual scholarship.

AMA Book On New Drugs

The Council on Drugs of the American Medical Association plans to begin this month distribution of a book entitled "New Drugs."

The book is designed to meet the specific needs of the practicing physician for a source of up-to-date, authoritative and unbiased information on single entity drugs introduced within the past 10 years.

Physicians may purchase the 500-page book from the AMA for $5.00 per copy.

College of Chest Physicians Plans Meeting in New York City

The American College of Chest Physicians will hold its annual meeting at the Waldorf Astoria Hotel in New York City, June 17-21.

Dr. Alfred Goldman of St. Louis, President of the College, will preside. The scientific program will include postgraduate seminars, panel and round table luncheon sessions, formal papers and motion pictures.

The opening scientific session on Saturday, June 19, will include a symposium on thromboembolic disease and discussions of pulmonary hypertension, transplantation, hyperbaric oxygen therapy, mycobacterial disease and cardiac perplexities. On Sunday, there will be sessions on infiltrative lung disease, coronary artery disease, hypertension, emphysema, acute respiratory failure, cardiovascular emergencies and congenital heart disease.

The College and the American Medical Association will hold a combined meeting at the Barbizon-Plaza Hotel on Monday, June 21, with regular scientific sessions and six round table luncheon sessions.

Additional information may be obtained by writing to the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Auxiliary Officers Attend Board Meeting at Mont Chateau

The annual Spring Meeting of the Executive Board of the Woman's Auxiliary to the West Virginia State Medical Association was held at Mont Chateau Lodge, near Morgantown, April 26-27.

Mrs. George A. Curry, the President, presided at the business session which was attended by 35 state officers, standing committee chairmen, county presidents and county presidents elect.

It was announced that two women had accepted invitations to speak at the annual convention of the Auxiliary at The Greenbrier in White Sulphur Springs in August. They are Mrs. Richard Sutter of St. Louis, President Elect of the Woman's Auxiliary to the American Medical Association, and Mrs. Jordan Kelling of Waverly, Missouri, President of the Southern Medical Auxiliary.

After the business session on Monday, April 26, the West Virginia University Chapter of the Woman's Auxiliary to the Student American Medical Association presented a skit. The presentation was a mock fashion show entitled "Outfits Medical Wives Might Wear."

Drs. Clark K. Sleeth, Dean of the WVU School of Medicine, and George A. Curry of Morgantown, members of the Advisory Board, and Dr. Robert Tchou were honor guests at a dinner that night at Lakeview Country Club.

A workshop session on Tuesday, April 27, was under the direction of Mrs. Wilson P. Smith of Huntington, President Elect of the Auxiliary. Guest speakers were Doctor Sleeth and Dr. Albert C. Esposito, President of the West Virginia State Medical Association.

New Association Members

Dr. Joseph W. Blevins, Olin Mathieson Chemical Company, Hannibal, Ohio (Wetzel). Doctor Blevins, a native of Volant, Pennsylvania, was graduated from Geneva College and received his M. D. degree in 1947 from the University of Maryland School of Medicine. He served for two years as a Captain in the Medical Corps of the U. S. Army and he previously was located in Lynn, Massachusetts. His specialty is occupational medicine.

* * * *

Dr. Zeb C. Burton, Jr., 1115 16th Street, Huntington (Cabell). Doctor Burton, who was born in Orange County, North Carolina, received his M. D. degree in 1957 from the Bowman Gray School of Medicine. He interned and served a residency at Grady Memorial Hospital in Atlanta, Georgia, and he served for two years as a Captain in the Medical Corps of the U. S. Air Force. His specialty is internal medicine and cardiology.

* * * *

Dr. Julian D. Gasataya, Main Street, Lumberport (Harrison). Doctor Gasataya, who was born in the Philippines, was graduated from San Agustin University and received his M. D. degree in 1956 from the University of Santo Tomas in Manila. He interned at Ohio Valley Hospital in Steubenville, 1957-58, and served residencies at that hospital and at Mansfield General Hospital in Mansfield, Ohio, and the Ohio Valley General Hospital in Wheeling, 1960-64. His specialty is general surgery.

* * * *

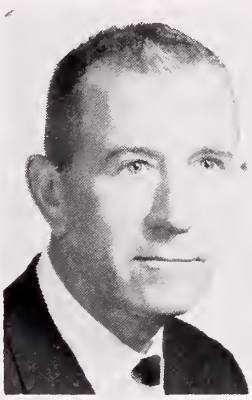
Dr. Edwin C. Neville, 1323 Quarrier Street, Charleston (Kanawha). Doctor Neville, a native of Youngstown, Ohio, was graduated from John Carroll University and received his M. D. degree in 1951 from the St. Louis University School of Medicine. He interned at Western Reserve University Hospital in Cleveland, 1951-53, and served residencies at St. Louis University Hospital and the State University of Iowa Hospital. He served for two years as a Lieutenant in the Medical Corps of the U. S. Navy and he formerly served as assistant professor of surgery at the State University of Iowa School of Medicine. His specialty is thoracic and cardiovascular surgery.

* * * *

Dr. John H. Wolf, Jr., Willey Street Medical Building, Morgantown (Monongalia). Doctor Wolf, a native of Grafton, was graduated from West Virginia University and received his M. D. degree in 1961 from the Bowman Gray School of Medicine of Wake Forest College. He interned at North Carolina Baptist Hospital in Winston-Salem, 1961-62, and served residencies at that hospital and at the West Virginia University Hospital, 1962-64. He is currently serving as Clinical Instructor in Pediatrics at the WVU School of Medicine.

Dr. Leckie Installed as President Of W. Va. Chapter, AAGP

Dr. Jack Leckie of Huntington was installed as President of the West Virginia Chapter of the American Academy of General Practice during the 13th Annual Scientific Assembly which was held at Oglebay Park in Wheeling, April 30 to May 2.



Jack Leckie, M. D.

Doctor Leckie succeeds Dr. Peter A. Haley of Charleston. Dr. L. Dale Simmons of Clarksburg was named President Elect and will assume his duties as President at the annual meeting next Spring.

Other officers elected are as follows:

Dr. Martha J. Coyner of Harrisville, Vice President; Dr. Del Roy Davis of Kingwood, Secretary; and Dr. C. Carl Tully of South Charleston, Treasurer.

Dr. Carl B. Hall of Charleston and Dr. Seigle W. Parks of Charleston were named delegates to the AAGP. Alternates are Drs. Halvard Wanger of Shepherdstown and J. Keith Pickens of Clarksburg.

The New Academy President

Doctor Leckie, the new President, is a native of Toler, Kentucky, and received his M. D. degree in 1950 from the George Washington University School of Medicine in Washington, D. C.

He was named President Elect at the 1964 meeting in Charleston. Doctor Leckie is a member of the Cabell County Medical Society, West Virginia State Medical Association and the American Medical Association.

Guest Speakers

Sixteen prominent physicians and surgeons appeared as guest speakers at the scientific sessions held during the meeting.

Dr. Edward H. Rynearson, Senior Consultant in Endocrinology and Metabolism at the Mayo Clinic, was the principal speaker at the annual banquet on Saturday night, May 1. His subject was: "It's Hard to Live With a Doctor Or a Doctor's Wife."

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, also spoke at the banquet.

Donation For Camp Galahad

The Monongalia County Medical Society has donated $500 to Camp Galahad through the West Virginia Diabetes Association.

The gift represents funds left over from polio immunization clinics in Monongalia County. Camp Galahad is a facility in Clay County for diabetic, deaf, blind and mentally retarded children.

Dr. E. F. Heiskell, Jr., of Morgantown (left) is the new President of the West Virginia Chapter, American College of Surgeons. Other officers shown during the annual meeting at The Greenbrier in White Sulphur Springs are (left to right): Drs. T. P. Mantz of Charleston, Vice President; Harry F. Cooper of Beckley, Secretary-Treasurer; Charles M. Scott of Bluefield, Governor; and Hu C. Myers of Philippi, Past President and Councilor.

Dr Edgar F. Heiskell New President Of W. Va. Chapter, ACS

Dr. Edgar F. Heiskell, Jr., of Morgantown was installed as President of the West Virginia Chapter, American College of Surgeons, at the Chapter's annual meeting at The Greenbrier in White Sulphur Springs, April 29-May 1.

Other new officers are: Dr. T. P. Mantz of Charleston, Vice President; and Dr. Harry F. Cooper of Beckley, Secretary-Treasurer. Dr. Hu C. Myers of Philippi is the retiring President.

Fifteen scientific papers were presented during the three-day meeting. Included were research papers by Drs. Mihbi Shy'ayb and Kenneth E. Thomas, both surgical residents at the West Virginia University Medical Center. Doctors Thomas and Shy'ayb won first and second places, respectively, in competition for residents.

The Chapter will have another meeting in Morgantown, October 1-2, the weekend of the Pitt-West Virginia football game.

Participating in the scientific program will be Drs. Albert J. Paquin, Jr., Chairman of the Department of Urology at the University of Virginia; and Mark Ravitch, Associate Professor of Surgery at Johns Hopkins University School of Medicine.

Members of the staff of the Department of Surgery at the West Virginia University Medical Center also will present papers.

Further information concerning the October meeting may be obtained by writing to Dr. Richard A. Currie, Department of Surgery, WVU Medical Center, Morgantown.

Cancer Society Increases Grants For Research Projects

The American Cancer Society has approved 123 research grants totaling $3,667,158 to scientists and research institutions throughout the country.

Dr. Alvin L. Watne of the West Virginia University School of Medicine will receive additional funds to increase his grant to $22,356. Doctor Watne is studying factors affecting tumor growth and metastases in experimental animal tumors and methods of metastases prevention.

The American Cancer Society's grants in West Virginia currently total $63,213.

SK&F Lists Services

Smith Kline & French Laboratories recently publised a *Catalog of Services* for distribution to physicians.

The booklet lists and describes films, publications and other services that SK&F offers to doctors without charge.

Copies may be obtained by contacting the local SK&F representative or by writing to Services Department, Smith Kline & French Laboratories, 1500 Spring Garden Street, Philadelphia, Pennsylvania 19101.

Dr. Amos N. Johnson Installed As President of AAGP

Dr. Amos N. Johnson of Garland, North Carolina, was installed as president of the American Academy of General Practice during the 17th Annual Scientific Assembly in San Francisco, April 12-16.

Named president elect was Dr. Carroll L. Witten of Louisville, Kentucky, who served as Speaker of the Congress of Delegates for the past five years. He will be installed as president at the next convention in Boston, October 8-14, 1966.

Several West Virginia physicians participated actively in the meeting which attracted more than 2,800 physicians and a total registration of 6,489.

Dr. Carl B. Hall of Charleston served as Chairman of the Reference Committee on Miscellaneous Business and he also presented a paper on "Induction of Labor" during a symposium on obstetrics and gynecology.

Dr. Seigle W. Parks of Charleston was honored by being named to serve as Chairman of the Committee on Scientific Assembly for the coming year. He will be in charge of the committee planning the program for the 1966 meeting in Boston.

ACCP Loan Program Established

The American College of Chest Physicians is offering loans to resident physicians in the United States and Canada to assist them in completing residencies in cardiovascular and pulmonary diseases.

Application forms may be obtained by writing to the Committee on Resident Loan Fund, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Medical Meetings, 1965

The following is a partial list of national, state and district medical meetings scheduled for 1965:

June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia

Make Your Reservation Now !

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 98th Annual Meeting at The Greenbrier in White Sulphur Springs, August 26-28, 1965. Application forms for room reservations have been mailed to members and additional copies are available upon request. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

AMA Auxiliary Meeting Planned In New York City

The 42nd Annual Convention of the Woman's Auxiliary to the American Medical Association will be held at the Americana Hotel in New York City, June 20-23.

Mrs. George A. Curry

Mrs. George A. Curry of Morgantown, President of the Woman's Auxiliary to the West Virginia State Medical Association, will head the state delegation. It is expected that a large number of auxiliary members from West Virginia will travel to New York City for the meeting.

More than 3,500 wives of physicians are expected to attend the meeting, which will be held in conjunction with the Annual Meeting of the AMA.

Mrs. William H. Evans of Youngstown, Ohio, the President, will preside at the four-day meeting. Mrs. Richard A. Sutter of St. Louis, the President Elect, will be installed as President during the meeting.

Dr. Donovan F. Ward, President of the AMA, will be the guest speaker at the annual luncheon honoring past presidents which will be held on Tuesday, June 22. The Auxiliary's annual contribution to the AMA-ERF also will be announced at that time.

Mrs. Sutter will preside at a post-convention conference for new officers and committee chairmen on Thursday morning, June 24. The speaker will be Dr. Ernest B. Howard, Assistant Vice President of the AMA.

An interesting entertainment program has been arranged for children who accompany their parents to the meeting. The complete program for the Auxiliary meeting was published in the May 10 issue of the *JAMA*.

Funds For Heart Research

The West Virginia Heart Association is now accepting applications for research grants in the field of cardiovascular disease. Grants are not restricted to any particular discipline although the investigator must be qualified and have available facilities necessary to pursue his investigation.

Individual requests for grants should not exceed $3,000, although no maximum has been established by the Association's Research Committee. Awards will be based on merit, need and available funds.

All requests for the 1965-66 fiscal year should be submitted as soon as possible, and no later than June 30. Application blanks and additional information may be obtained by writing to the Research Committee, West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

114th Annual AMA Meeting In New York, June 20-24

More than 25,000 physicians are expected to attend the 114th annual convention of the American Medical Association in New York City, June 20-24.

Physician registration was 23,083 when the AMA held its last convention in New York City in 1961.

Donovan F. Ward, M. D.

James Z. Appel, M. D.

Dr. Donovan F. Ward of Dubuque, Iowa, President of the AMA, will preside at the meeting. The program also will feature the installation of Dr. James Z. Appel of Lancaster, Pennsylvania, as President.

Headquarters for the meeting will be the Americana Hotel. The scientific sessions will be held in the huge New York Coliseum, which also housed the 1961 convention. Several scientific meetings, however, will be held in hotels in the mid-town area.

Dr. J. Arnold Bargen of Temple, Texas, Chairman of the Council on Postgraduate Programs, said the New York City program will be most comprehensive, including lectures, scientific exhibits, preview showings of medical films and color television. The Council plans the scientific programs for AMA's two conventions each year.

"The combined efforts of many people, particularly the specialty section secretaries, have helped to formulate a program that will be an outstanding contribution to graduate medical education," Doctor Bargen said.

The New York convention will feature six general scientific sessions, which will offer to physicians the most recent findings in adverse drug reactions; organ transplantation; hearing; nonnarcotic drug addiction; metabolism in growth development and aging, and diagnostic cytology. In addition to the general scientific sessions, 23 specialty sections also will have programs.

The complete convention program was published in the May 10 issue of the *JAMA*.

Drs. Frank J. Holroyd of Princeton and Charles A. Hoffman of Huntington will represent the West Virginia State Medical Association in the AMA House of Delegates. Alternates are Drs. D. E. Greeneltch of Wheeling and Thomas G. Reed of Charleston.

27 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board of West Virginia licensed 16 physicians, 8 by examination and 8 by reciprocity, at a meeting held at The Capitol in Charleston, January 11-13, 1965. The following physicians were licensed by direct examination:

Andrews, Frank Baker, Jr., Ft. Eustis, Virginia
Chu, Hyeun Soon, Weston
Daneault, Fernand Joseph, Hampton, Virginia
Gettliffe, Cyril Dudley, Parkersburg
Napoli, Victor M., Morgantown
Neale, Richard Carroll, Jr., Richmond, Virginia
Stock, Rodolfo, South Charleston
Swartz, Donald Reed, Morgantown

The following is a list of the physicians who were licensed by reciprocity:

Adams, Curtis L. V., Man
Anderson, Mary M., Man
Hughes, James Thomas, Morgantown
Januszeski, Francis Joseph, Clarksburg
Jenkins, Robert Allen, St. Marys
Rudnick, Abraham H., Man
Suttenfield, Frederick Daniel, Romney
Weimer, George A., Wheeling

At a meeting of The Medical Licensing Board of West Virginia, the following 11 physicians were licensed by reciprocity on April 12, 1965:

Dewing, Stephen Bronson, Morgantown
Hodges, Wyllys Royce, Jr., Cumberland, Maryland
Jacobs, William Harold, Morgantown
Johnson, James Byrd, Ewing, Virginia
Newton, Roger Eugene, Fairmont
Nugent, Milton Everett, Wheeling
Poffenbarger, Arthur Lee, Dunbar
Simmons, William Charles, Logan
Sowder, Wilson Thomas, Jr., Alderson
West, James Edward, Shinnston
Woelfel, James Thomas, Augusta, Georgia

Fellowship Fund Established in Memory Of Dr. Norman H. Jolliffe

New York City has established a fellowship fund in memory of a graduate of West Virginia University.

The late Dr. Norman Hayhurst Jolliffe, a 1923 graduate of WVU, is being honored for his contributions to medicine and public health nutrition.

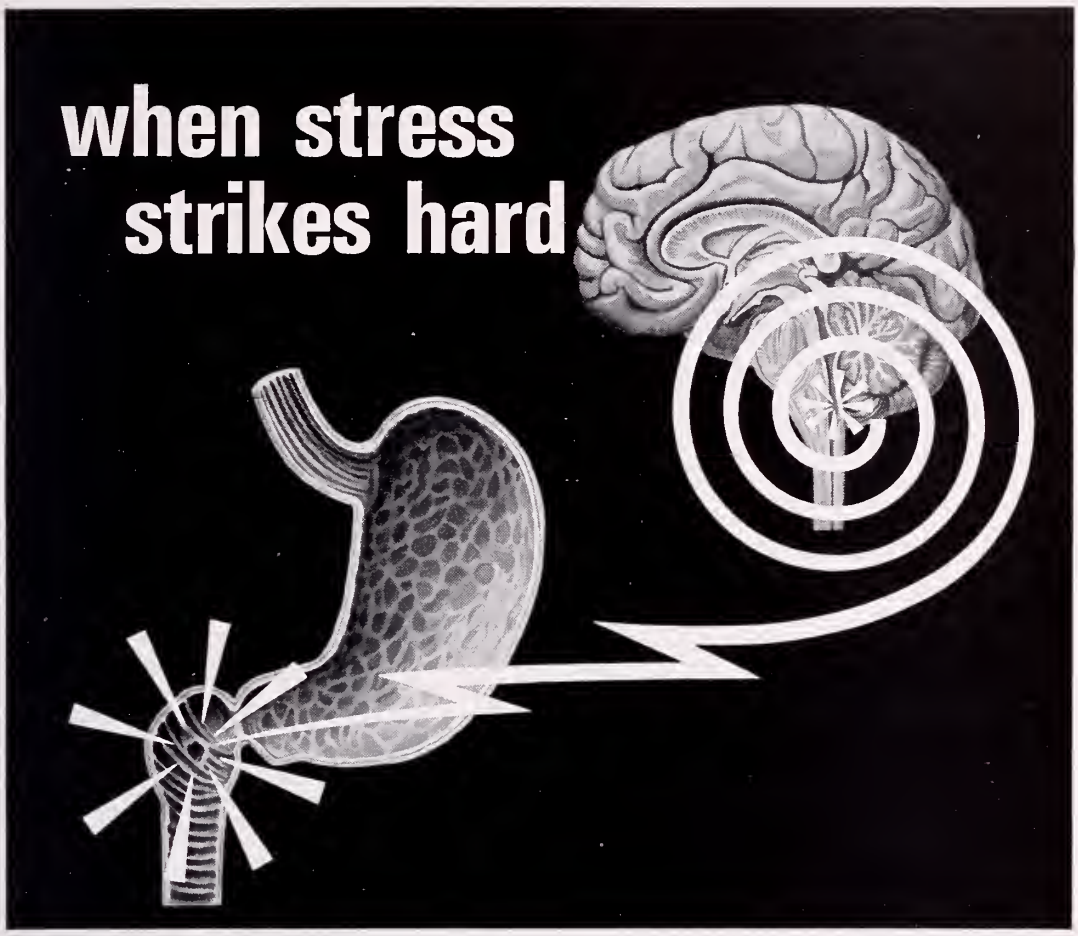
The Norman Jolliffe Fellowship Fund was announced by New York City's Department of Health.

In a letter to the scientist's colleagues, the Department said the "fund will provide scholarships to excellent young physicians to enable them to participate in clinical and research aspects of the fascinating science of nutrition."

Doctor Jolliffe conducted nutrition status surveys in Brazil and Formosa and served as a member of the Newfoundland International Survey teams of 1944 and 1948. He is the author of two standard texts in nutrition: "Reduce and Stay Reduced," and "Reducing Diet Guide." Both were published in 1952.

Doctor Jolliffe died in 1961.

Tax deductible contributions can be made to the Norman Jolliffe Fund by writing to William Shea, Secretary-Treasurer, 270 Madison Avenue, New York, New York 10016.



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Dosage: One tablet three times a day.

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Research in the Service of Medicine

WVU Medical Center
–News–

Two long-time professors at the West Virginia University School of Medicine are co-authors of a book entitled "A History of Medical Education in West Virginia," which is to be published by the University Library this summer.

The authors are Dr. Edward J. Van Liere, Dean Emeritus of the School of Medicine, and Dr. Gideon Dodds, Professor Emeritus of Histology and Embryology.

Doctors Van Liere and Dodds began research for the book in 1953. The book, consisting of 16 chapters, traces medical education in West Virginia from 1868 to construction of the WVU Medical Center in the 1950s. One chapter is devoted to brief biographical sketches of some of the early medical educators in the state.

The authors obtained much of their information firsthand. Doctor Dodds has been at WVU since 1918. Doctor Van Liere joined the staff three years later and became Dean in 1935.

New Members of Faculty

Dr. Joseph R. Lancaster, Jr., a native of Charles Town, has been appointed assistant professor of surgery at the West Virginia University School of Medicine, effective July 1.

Doctor Lancaster will teach and practice general and thoracic surgery at the Medical Center and at the Veterans Administration Hospital in Clarksburg. He has been serving as an instructor in surgery at the University of Chicago Clinics.

Doctor Lancaster received his bachelor of science degree from WVU and his M. D. degree in 1958 from the University of Chicago. He completed intern and residency programs at the Chicago Clinics.

Dr. Robert J. Herm assumed duties April 22 as Assistant Professor of Ophthalmology in the Department of Surgery at the West Virginia University School of Medicine.

Doctor Herm has been associated with Massachusetts Eye and Ear Infirmary in Boston, where he was an assistant surgeon in ophthalmology. He served a residency at the Infirmary after receiving his M. D. degree from Cornell University in 1949.

His memberships include the American Academy of Ophthalmology and Otolaryngology and the American College of Surgeons.

• **Compiled from moteriol furnished by Arthur V. Ciervo, Director, Medicol Center News ond Informotion Services, Morgantown, West Virginia.**

Surgery Residents Receive Awards

Two surgery residents at West Virginia University Hospital have earned awards for surgical research.

Dr. Kenneth E. Thomas earned a prize of $100 for a paper entitled "Diagnostic and Surgical Aspects of Atrial Tumors." Dr. Wihbi A. Shy'ayb was awarded $50 for a paper on "Studies of the Mechanism of Anti-Diuretic Hormone Secretion and the Post-Commissurotomy Syndrome."

Doctors Thomas and Shy'ayb presented their papers at the annual meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs, April 29-May 1.

Eight medical students and a faculty member at West Virginia University were installed recently as members of the West Virginia Alpha Chapter of Alpha Omega Alpha, honor medical society. New members are (front row, left to right): Dr. Charles E. Andrews, Professor of Medicine; Joseph Rhudy of Lewisburg, and Samuel Strickland of Summersville. Second row: Paul M. Chikos of Logan, Harvey Reisenweber of Baltimore, Donald Glass of Uniontown, Pennsylvania, and Erskine Caperton of Mount Hope. Not present when picture was made were Linda Lewis of Beech Bottom and Billie Atkinson of Reedy.

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The Month in Washington

• From the Washington Office of the American Medical Association.

A Registry of Tissue Reactions to Drugs is being established here within the Armed Forces Institute of Pathology (AFIP) through the cooperation of the American Medical Association, the Pharmaceutical Manufacturers Association and the Food and Drug Administration.

The AFIP has the world's largest repository of pathological material for research and education, and the registry is expected to be a major addition to existing adverse drug reaction reporting programs.

"This unique cooperative effort for the benefit of the American public is the first between major drug manufacturing, drug prescribing and drug regulating bodies," said a joint statement issued by Dr. Jean Weston, Director of the AMA Department of Drugs; Dr. Joseph Sadusk, FDA medical director, and Dr. Austin Smith, president of the PMA.

Purpose of Registry

The purpose of the Registry will be to obtain autopsy or biopsy tissue specimens from suspected adverse drug reaction cases. These specimens will be thoroughly studied by all methods available to a full-time pathologist, including consultation with other authorities in pathology and toxicology. Results of the studies will be reported to local pathologists who furnished the study material, and monthly summary reports will be made to each of the three sponsoring organizations. Important information obtained will then be disseminated to the medical community. The pathological material will remain on file at the Registry for future reference and study.

The Tissue Registry will augment the existing drug reaction reporting programs maintained by the AMA and FDA. The FDA at present receives reports of suspected adverse drug reactions from about 500 cooperating federal and military hospitals, and from 110 civilian hospitals under contract.

The AMA receives such reports from physicians in private practice, a number of hospitals not reporting to FDA, and other sources.

Information is exchanged by the FDA and AMA, catalogued by data-processing techniques, and filed by data-processing machines. The data are then available for use in identifying drugs possibly associated with adverse reactions, in assisting physicians to diagnose possible adverse drug reactions, and in scientific investigations.

Establishment of the Tissue Registry was originally proposed by the Drug Research Board of the National Academy of Sciences-National Research Council. Twenty-eight such Registries already exist as joint activities of the Armed Forces Institute of Pathology and sponsoring professional societies. Collectively, the Registries are known as the American Registry of Pathology.

The parent Armed Forces Institute of Pathology, which is more than 100 years old, serves as a central laboratory of pathology for the Department of Defense and has become a center of research, teaching and consultation not only for the military but for civilian groups. AFIP officers and laboratories are in an eight-story building at Walter Reed Army Medical Center.

The cost of the Tissue Registry is being borne equally by each of the three sponsors. In its first full calendar year of operation (1966), the cost of operation and administration is expected to be about $100,000. The fund will be administered by the Universities Associated for Research and Education in Pathology, Inc.

In another development in this field, the U. S. delegation proposed at the World Health Organization Assembly in Geneva, Switzerland, that there be a worldwide warning system against drugs with adverse effects.

In commending the proposal, which was recommended by the HEW department, President Johnson said:

"The expansion of this into an international system would be of direct benefit to the American people since it would include the monitoring of adverse reactions throughout the world.

"This is one of the many instances in international technological cooperation where everybody gains and no one loses."

Congress has approved legislation authorizing more than $100 million to finance a three-year extension of a program of federal aid to community health services, including immunization programs against polio and measles.

The American Medical Association supported the provisions for immunization programs and most other features of the legislation.

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Obituaries

ROY G. CONRAD, M. D.

Dr. Roy G. Conrad, 54, a physician in Weirton since 1955, died on April 24 at a hospital in Pittsburgh.

Doctor Conrad was born in Lebanon, Pennsylvania, on November 18, 1910. He received his M. D. degree from Jefferson Medical College in Philadelphia in 1935 and came to Weirton from Providence, Rhode Island.

Doctor Conrad interned at Lancaster General Hospital in Lancaster, Pennsylvania, 1936-37, and served a residency at Wadsworth Veterans Hospital, 1947-50.

He served as a Lieutenant Commander in the Medical Corps of the U. S. Navy during World War II and was a member of the Hancock County Medical Society, the West Virginia State Medical Association, and the American Medical Association. He was certified by the American Board of Surgery and was a member of the American College of Surgeons.

Besides his widow, he is survived by two daughters, Susan Ann, a student at Valpariso University, and Bonnie Kay, a student at Weir High School; his father; a brother, Carl Conrad of New York City; and three sisters, Mrs. June Cotton of Westport, Connecticut, Mrs. Lucille Gessler of New York City, and Mrs. Florence Heath of York, Pennsylvania.

$2.3 Billion in Hospital Expense Benefits Paid in 1964

Insurance companies paid out a total of $2,326,000,000 in 1964 to insured persons to help them pay their hospital bills, the Health Insurance Institute reported recently.

That figure, the Institute said, represents an average of $6.4 million a day. The companies' payments were made under hospital expense policies and under the portion of major medical expense programs which provide for hospital charges.

These benefits helped pay for hospital charges for room and board, drugs and medicines, laboratory services, x-rays, routine nursing, operating room and other hospital services.

Including health insurance payments for other than hospital care, insurance companies last year distributed total benefits of near $4.7 billion, a 12.2 per cent climb over 1963.

For over two decades there has been continuous growth in the amount of hospital expense benefits paid by all insuring organizations, which, in addition to insurance companies, include Blue Cross, Blue Shield and similar health care plans. This growth, stated the Institute, can be shown by an analysis of hospital benefits paid during 1953 and 1963, the last year for which data from all insuring organizations are available.

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E. C. Voss, M. D.

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G. J. Pentecost, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Nancy Fondriest, M. T.

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County Societies

B-R-T

Dr. Edwin C. Neville of Charleston was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society which was held at the Tavern Restaurant in Philippi on April 15.

Doctor Neville presented an interesting paper on "Obstructive Lesions of the Esophagus."

Drs. Karl J. Myers of Philippi, Donald R. Roberts of Elkins and S. M. Lilienfeld of Parsons were named to a nominating committee for the election of 1966 officers.

Dr. R. B. Ormsbee was elected to membership in the Society.

Sixteen members and guests were present at the meeting.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Dr. Page H. Seekford, Director of the Kanawha-Charleston Health Department, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society in Huntington on April 8.

Doctor Seekford, who was instrumental in establishing two birth control clinics for the indigent in Kanawha County, discussed "Family Planning."

The Cabell County Society adopted a motion endorsing the principle of family planning and advocating support of the Cabell County Health Department in the establishment of a birth control clinic.

Drs. R. Moore Dodrill and Donald Robert Bernhardt were elected to membership in the Society.—Harold N. Kagan, M. D., Secretary.

* * * *

HARRISON

Dr. Richard K. Hanifan was installed as President of the Harrison County Medical Society at the Society's regular monthly meeting which was held at the Stonewall Jackson Hotel in Clarksburg on May 6.

Doctor Hanifan succeeds Dr. A. Robert Marks as President. Other new officers are: Dr. James A. Thompson, President Elect; Dr. Paul E. Gordon, Secretary; and Dr. E. L. Linger, Treasurer.

Annual committee reports were presented and it was noted that the medical loan fund has granted loans to four Harrison County college students this year. Three other loans are pending.

* * * *

LOGAN

Dr. Albert C. Esposito, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Logan County Medical Society in Logan on April 14.

Doctor Esposito discussed the socialized medicine package that had been passed a few days earlier by

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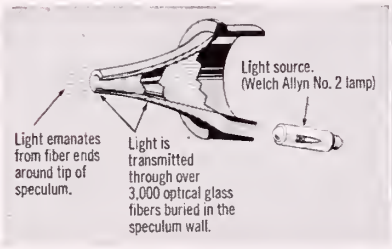

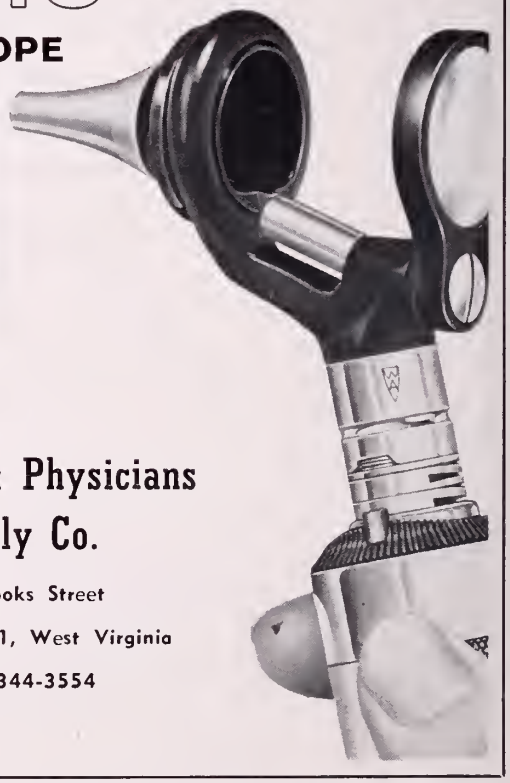

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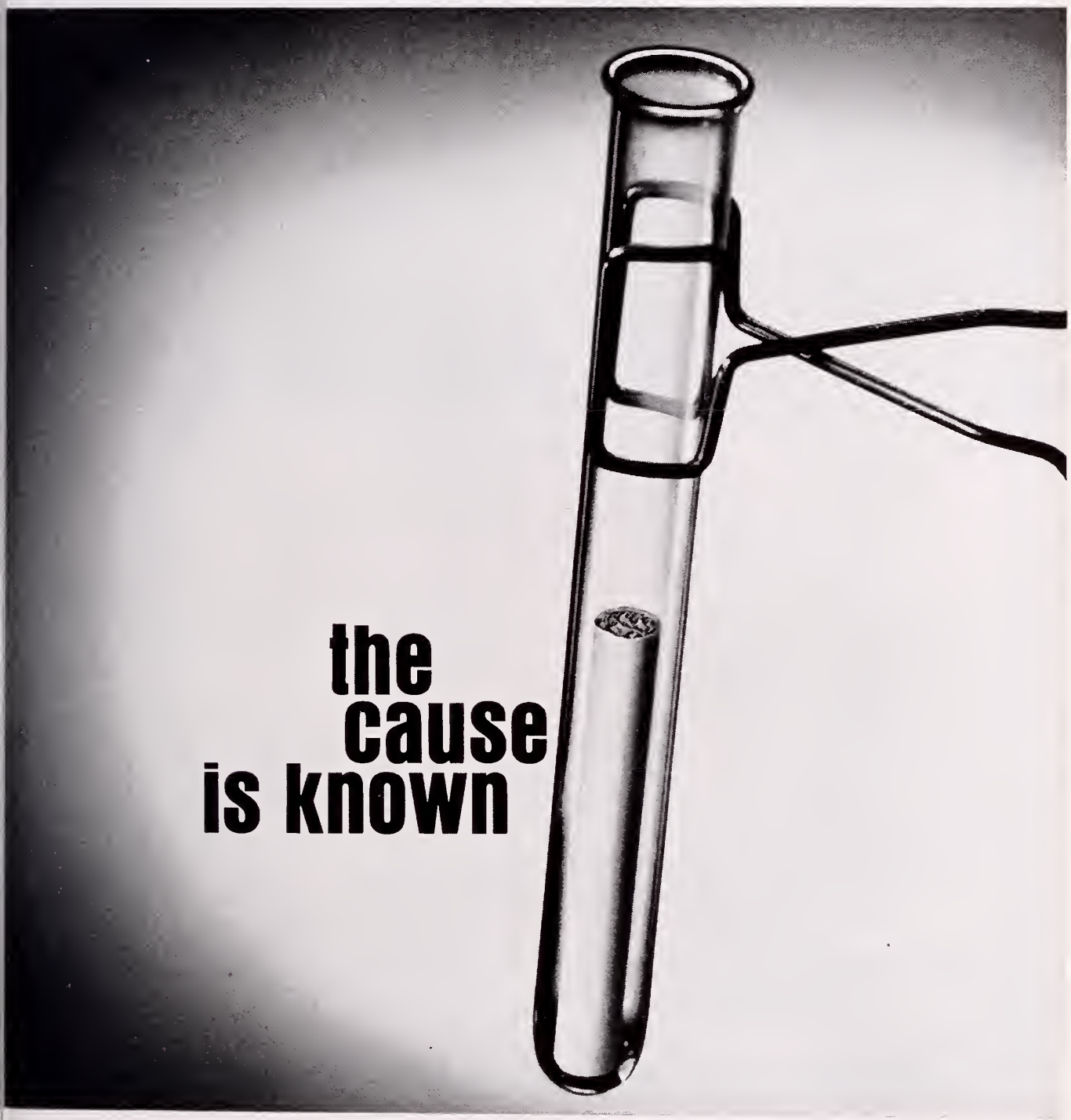
As the evidence piled up, the Society intensified its public educational efforts, with teen-agers the specific target. Many private and government agencies were stimulated to take action.

But people have short memories. Already the message of the Surgeon-General's report has been blurred with the passage of time. Unless those with the responsibility for protecting health act vigorously, the public will continue to lose sight of the risk . . . and smoke cigarettes.

We are faced with some compelling questions. How to motivate adults to stop smoking cigarettes? How to influence teen-agers not to start? How to help those who want to stop but can't?

Between us, doctor, we must find the answers. **american cancer society**®



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the U. S. House of Representatives. He urged doctors to continue their resistance to certain features of the program.

A lively question and answer period followed Doctor Esposito's talk.

The Society elected Dr. Abraham H. Rudnick of Man to membership.

* * * *

McDOWELL

Dr. Richard O. Rogers, Jr., of Bluefield was the guest speaker at the regular monthly meeting of the McDowell County Medical Society at Stevens Clinic Hospital in Welch on March 7.

Doctor Rogers presented an interesting paper on polycythemia.

The Society voted to donate $70 to send one child to Camp Kno-Koma.—David J. Skewes, M. D. Secretary.

* * * *

MERCER

Dr. Albert C. Esposito, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society at the West Virginian Hotel in Bluefield on April 19.

Doctor Esposito reviewed federal medical legislation and urged doctors to defend the free practice of medicine.

Dr. Sam Milchin, President of the Society, asked members to stand for a minute of silent prayer in memory of the late Dr. Wade H. St. Clair.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Hubert T. Marshall was the speaker at the regular monthly meeting of the Monongalia County Medical Society in Morgantown on March 2.

Doctor Marshall discussed a proposal to build a 250-bed nursing home to replace the Sundale Nursing Home. The project would be used by Monongalia and Preston counties. The building site would be near the present nursing home.

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, was the guest speaker at the Monongalia County Society's meeting on April 6.

Doctor Esposito urged that all possible influence of organized medicine be brought on behalf of the Eldercare Bill.—William E. King, M. D., Secretary.

* * * *

PRESTON

Dr. and Mrs. C. Y. Moser entertained members of the Preston County Medical Society and their wives with a dinner at their home on April 25.

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A number of workers have reported major improvement in 50-75% of cases, with some successful cases going into complete remission.

In responsive cases, improvement is generally seen within a week, so that trial therapy need seldom be continued beyond this period. Alleviation of pain is followed quickly by improvement of function and resolution of effusion or other signs of active inflammation. Relief of arthritic symptoms is quite frequently accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

Precautions
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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The dinner marked the annual Doctors Day observance. Members of the Auxiliary presented each doctor with a red carnation for his lapel.

Eighteen persons attended the dinner.

* * * *

RALEIGH

Dr. Warren D. Elliott, President of the Raleigh County Medical Society, has been named president pro tem of a "Parents' League" in Raleigh County.

Steps toward organizing the league were taken April 22 at a dinner in Beckley sponsored by the Medical Society and attended by more than 70 civic leaders, clergymen, educators, judges and law enforcement officers.

The group will adopt later a code of behavior for teen-agers and other children. Doctor Elliott appointed a committee to compose a preliminary set of guidelines that will concern drinking, driving, dances, dress and dating deadlines. The recommendations will be considered at another general meeting.

Dr. Geolo McHugh, Associate Professor of Psychology at Duke University, was principal speaker at the organizational session. He emphasized that establishment of a code of behavior was not to be construed as drawing battlelines between parents and children.

Woman's Auxiliary

to the

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Second Vice President: Mrs. C. J. Holley, Wheeling
Third Vice President: Mrs. J. A. B. Holt, Charleston
Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William B. Rice, Dunbar.

HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held a dinner meeting on May 6 at the Stonewall Jackson Hotel in Clarksburg.

Mrs. Albin A. Galuszka, Program Chairman, introduced the speaker, Dr. Robert S. Wilson, who gave an interesting talk on old homes in Harrison County. Doctor Wilson is a member of the Harrison County Medical Society and the Harrison County Historical Society.

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The following officers were installed for 1965-66: Mrs. A. Robert Marks, President; Mrs. Galuszka, President Elect; Mrs. Hugh M. Brown, Vice President; Mrs. Phillip W. Hall, Secretary; and Mrs. Boylston D. Smith, Treasurer.—Mrs. Karl A. Dillinger, Publicity Chairman.

* * * *

KANAWHA

The Auxiliary to the Kanawha Medical Society met at the home of Dr. and Mrs. P. A. Tuckwiller in Charleston on May 11.

Mrs. J. A. B. Holt, Regional Director of the Auxiliary to the West Virginia State Medical Association, installed the incoming officers, which included Mrs. James Walker, the President.

Mrs. Walker announced the following were appointed to offices: Mrs. J. D. Kugel, Financial Secretary; Mrs. Marshall J. Carper, Historian, and Mrs. Joseph A. Smith, Parliamentarian.—Mrs. A. A. Abplanalp.

* * * *

MARION

Mrs. Robert G. Janes of Fairmont was installed as President of the Auxiliary to the Marion County Medical Society during a tea at the home of Dr. and Mrs. Joseph D. Romino on April 28.

Other new officers are: Mrs. James E. Wotring, President Elect; Mrs. Rupert W. Powell, Vice President; Mrs. Frederick G. Shaffer, Secretary, and Mrs. John J. Coogle, Treasurer.

Retiring President is Mrs. Franklin W. Mallamo.

Mrs. Powell reported on the spring board meeting at Mont Chateau.

* * * *

McDOWELL

Members of the Woman's Auxiliary to the McDowell County Medical Society had their annual tea in Welch on April 21 for members of the Future Medical Leaders.

About 140 students from various schools in the county attended. In the receiving line were Mrs. J. Hunter Smith, President of the Auxiliary; Mrs. Stephen Mamick and Mrs. J. H. Murry. Mrs. David Skewes was chairman for the tea.

Mrs. Mamick introduced the guest speaker, the Rev. J. A. Ryan, a Roman Catholic priest. Father Ryan gave an interesting talk on health problems in The Congo, where he served as a missionary.

* * * *

MONONGALIA

Mrs. Charles E. Andrews was installed as President of the Woman's Auxiliary to the Monongalia County Medical Society at a meeting of the Auxiliary at Lakeview Country Club in May.

Mrs. Andrews succeeds Mrs. Arthur W. Kelley. Other new officers include: Mrs. Robert Greco, President Elect; Mrs. Byron M. Bloor, Vice President; Mrs. J. J. Lawless, Secretary; and Mrs. Maynard P. Pride, Treasurer.

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RALEIGH

William Binderman, Vice President of the Raleigh County Mental Health Association, was the guest speaker at the April meeting of the Woman's Auxiliary to the Raleigh County Medical Society at the Beckley Hotel.

Mr. Binderman discussed "Homemaker Service" and expressed the hope that the Auxiliary might be interested in sponsoring the service in Raleigh County.

New officers for 1965-66 were presented. They are: Mrs. Warren D. Elliott, President; Mrs. E. B. Wray, President Elect; Mrs. Lewis N. Fox, Vice President; Mrs. I. B. Anderson, Corresponding Secretary; Mrs. William D. McLean, Recording Secretary, and Mrs. John M. Daniel, Treasurer.

The Auxiliary decided to give volunteer service to assist with Project Head Start in Raleigh County.

The Woman's Auxiliary to the Raleigh County Medical Society sponsored the annual Health Careers Day program in Beckley on April 10.

More than 100 Raleigh County high school students observed part of a routine day at Appalachian Regional Hospital. The students watched simulated emergency surgery, routine laboratory analysis and other procedures.

Mrs. John W. Whitlock was chairman of the Health Careers Day observance for the Auxiliary.

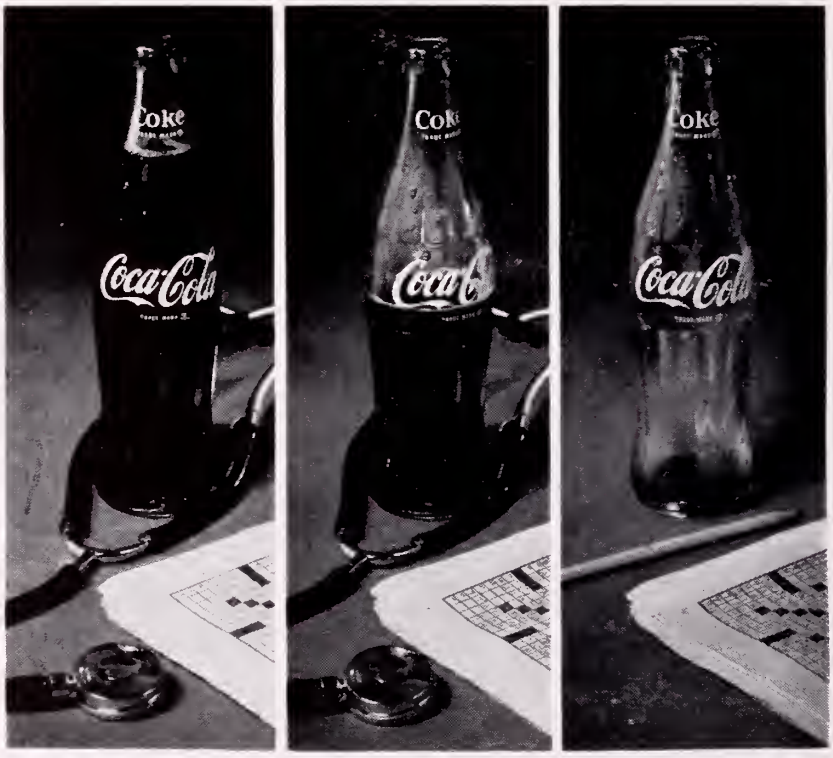
Book Reviews

FITNESS FOLIO—By Lawrence J. Frankel. Director of Frankel Institute. Charleston. West Virginia. Pp. 48, with illustrations. Gresham Printing Company, Charleston, West Virginia, 1965. Price $1.00.

In this interesting booklet entitled "Fitness Folio" are collections of exercises for the whole body. The book, divided into three parts, describes each exercise and gives an explanatory kinesiology that provides a ready reference for the doctor or other interested person.

The author has included from many sources the knowledge and fitness hints that appear in this publication. The "Folio" is the second edition and embraces much that was not included in the original edition. For example, certain exercises in each part have been added to the original group to round out a routine which is flexible for all ages and for all degrees of physical health and/or handicap.

Numerous physicians have contributed their ideas about fitness in recent years. The author has included a few such comments in the booklet. His own personal experiences and comments are presented modestly at appropriate points. At the end of the booklet a model chart is suggested for the benefit of those people who pursue an exercise program.



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The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke TRADE MARK

Publications such as this serve a useful purpose in the armamentarium of the busy physician, whatever his type of practice may be. For the patient needing guidance and inspiration in an exercise program, this booklet will prove an invaluable aid. It reads easily. It is amply illustrated. Above all, the booklet contains many pertinent suggestions drawn from the knowledge and experience of other physicians and from the author himself—suggestions for total fitness and better health!—William B. Rossman, M. D.

* * * *

RESPIRATORY FUNCTION IN DISEASE (An Introduction to the Integrated Study of the Lung)—By David V. Bates, M. D., Associate Professor of Medicine, McGill University; and Ronald V. Christie, M. D., Professor and Chairman of the Department of Medicine, McGill University. Pp. 566 with illustrations. Philadelphia and London: W. B. Saunders Company. 1964. Price $15.50.

The authors, both in the medical teaching department of McGill University at Montreal, Canada, give a highly informative report on the major problems in pulmonary disease under the heading of Definition—"Pathology, Radiology and Clinical Features."

The chapter on pulmonary emphysema is readily readable and will be most helpful to all physicians wishing to get an adequate background of understanding of this disease. The chapter on chronic bronchitis, preceding the one on emphysema, gives a good differentiation of these diseases. The pathology and x-ray reproductions are good. The indexing is excellent and the references are voluminous.

For general information and for special referral the book is highly recommended and should have a wide appeal to all physicians interested in this phase of medicine.

* * * *

COMMON BACTERIAL INFECTIONS—By Edwin J. Pulaski, Col., M. C., U. S. Army, Director, Division of Basic Research, Institute of Research, Walter Reed Army Medical Center, Washington, D. C. Pp. 301. Illustrated. W. B. Saunders Company, Philadelphia and London. 1964. Price: $8.50.

This 275-page book has a long chapter devoted to antimicrobial therapy which is helpful reading for any practicing physician. The section on penicillin may dispell some of the confusion received in the morning drug mail. The chapters on trauma, burns and infections are helpful to anyone in traumatic medicine. The remainder of the book is devoted to special studies of infection in the various bodily systems.

The information is given precisely and is substantiated by adequate reference. The book can be read with appreciation by all sections of medicine.

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How to Justify Treatment Risk

For an objective evaluation of drug toxicity, emphasis should be placed on the relative usefulness of a given drug as well as its potential harmfulness. Even such benign and essential agents as oxygen or water may be harmful when used inadvisedly as therapeutic agents.

Drugs of such established value as digitalis are potentially lethal when used in excess. It is thus apparent that the potential toxicity of drugs must be counterbalanced by emphasis on their proper usage.

The physician should be ever cognizant of the potential dangers of his medications as well as of their efficacy, and balance the two in determining the desirability of taking the risk involved. He should not use amidopyrine to treat a headache, but should have no hesitation is risking its potential harm when he needs an anti-pyretic for a patient with leukemia. The glucocorticoids should not be used in most patients with rheumatoid arthritis, but should never be withheld from patients with pemphigus.—Arthur Grollman, M. D., in Texas State Journal of Medicine.

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The West Virginia Medical Journal

July, 1965 Vol. 61, No. 7

Active Tuberculosis and Pregnancy

(Case Report)

Linda D. Lewis, M. D., and N. W. Fugo, M. D., Ph.D.

The therapy of pulmonary tuberculosis complicated by pregnancy has passed through many different phases since the time of Hippocrates. The present day concept is that pregnancy has no effect on the course of tuberculosis provided both are given adequate medical attention and treatment. Many investigators have studied the role of pregnancy and pulmonary tuberculosis in lung function and their effects upon each other. Analysis of blood gases of mothers, infants and placentas have been determined and the effects of changes in concentration have been studied. A review of the literature, however, failed to reveal a study of blood gases in a pregnant woman complicated by far advanced tuberculosis who underwent an uneventful labor and was delivered of a normal infant.

Case Report

P.W. (H13-37-58), a 27-year-old Caucasian female (GV PIV), was admitted to West Virginia University Hospital on May 12, 1964. She stated that she was in her thirty-sixth week of gestation and complained of a copius, frothy, fresh hemoptysis estimated to be 400 ml.

Past history revealed that active pulmonary tuberculosis had been diagnosed in June of 1959 up to which time she had had three pregnancies. Her children were born in May of 1956, March of 1957, and April of 1958. She was admitted to a state tuberculosis sanitarium (Pinecrest) with the diagnosis of far advanced, bilateral, active pulmonary disease. Her sputum on admission was positive for AFB and remained so throughout her stay of 97 days. Treatment consisted of bed rest and chemotherapy with PAS, INH and Streptomycin. She left the sanitarium against medical advice on September 20, 1959, classified as active TBC improved.

On November 13, 1959, she was admitted to another state sanitarium (Hopemont) with a diagnosis of far advanced, bilateral, active pulmonary tuberculosis, right lung, moderate, left lung, far advanced. Since six months of treatment with INH and PAS resulted in only fair response, the medication was changed to INH and Streptomycin. She was discharged on March 27, 1960, for disciplinary reasons, classified as active TBC improved. During this hospitalization sputum tests were reported as negative for AFB.

She was readmitted to the second sanitarium (Hopemont) on August 26, 1960, with the diagnosis of far advanced, bilateral active pulmonary tuberculosis, with a highly positive sputum. Chemotherapy consisting of INH and PAS was reinstituted but the sputum remained positive. X-ray examination showed only slight improvement. In March of 1961 therapy was changed to INH and Streptomycin. At this time surgical resection was recommended. A left pneumonectomy was performed on June 16, 1961, followed by a post-resection thoracoplasty on July 21, 1961.

Submitted to the Publication Committee, January 20, 1965.

The Authors

- **Linda D. Lewis, M. D., WVU Medical Center, Morgantown. Doctor Lewis received her M. D. degree from the West Virginia University School of Medicine on May 31, 1965.**
- **N. W. Fugo, M. D., Ph.D., Professor and Chairman of the Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Morgantown.**

Her recovery from both surgical procedures was satisfactory.

On September 12, 1961, she left the sanitarium against medical advice. On May 15, 1962, she was readmitted to the first sanitarium (Pinecrest) with a diagnosis of pulmonary tuberculosis complicated by pregnancy of approximately 8 months' gestation. Cultures of sputum were positive for AFB on admission. On June 8, 1962, an infant was delivered without complication. Treatment of the mother consisted of PAS and bedrest. X-ray revealed a cavity occupying the apex of the right lung. The infant was apparently normal. She was discharged on September 19, 1963, with medical advice as quiescent (maximal hospital benefit), with the recommendation that she continue PAS and INH for one year and then INH indefinitely.

Her first admission to West Virginia University Hospital in May of 1964 revealed a poorly nourished, chronically ill female in moderate respiratory distress with three to four pillow orthopnea.

Physical examination demonstrated a pulse of 110, B. P. 110/60, respirations 25 per minute. She had dyspnea on exertion, amphoric breathing in the upper right lung, moist rales in the middle and lower lung anteriorly, and a dull left hemithorax with evidence of an old thoracoplasty. She was not cyanotic or edematous.

Figure 1. X-ray demonstrating condition of patient's chest on admission to West Virginia University Hospital.

Abdominal examination revealed the uterus to be the size of a 24 to 26 week gestation, not commensurate with an EDC of June 26, 1964. The fetus was in breech presentation with FHT of 180. The liver was palpable two fingerbreadths below the right costal margin. The spleen could not be palpated. Reflexes were hypoactive but equal bilaterally. The remainder of the physical examination was within normal limits.

Chest x-ray (Figure 1) revealed a large (12 cm.) abscess cavity, with an air-fluid level in the right upper lobe; the right lower lobe had a slight increase in interstitial markings, possibly representing some interstitial infiltration without appreciable consolidation.

Sputum was positive for AFB; ECG demonstrated right axis deviation, probable right atrial hypertrophy and a sinus tachycardia. Urinalysis was normal. VDRL was nonreactive. Fasting blood sugar 72 mg. per cent. BUN 3 mg. per cent. Alkaline phosphatase 11 K-A units. BSP 6 per cent retention. CO_2 combining power 29 mEq/L. Sodium 136 mEq/L. Chloride 101 mEq/L. Potassium 3.9 mEq/L. Prothrombin time 17.3 with the control of 15.0. Serum bilirubin 0.1 mg. per cent at one minute and 0.2 total. Blood type O negative. Direct Coombs negative. Blood gas values were determined (Table 1).

On one occasion during this hospitalization, she experienced bright red hemoptysis and had numerous episodes of copious hemorrhagic, caseous sputum. Signs of congestive heart failure developed and she was consequently digitalized.

She smoked two packages of cigarettes per day for ten years prior to admission and continued to do so during this hospitalization. She was depressed and belligerent, refusing to eat on numerous occasions. On June 15, 1964, she went into labor and after approximately 5 hours without complication, a normal, viable 1,800 Gm. male infant 37.5 cm. in length was delivered under local anesthesia. She was given oxygen during delivery to help relieve some shortness of breath. Her postpartum course was uncomplicated except for depression and her refusal to return to a tuberculosis sanitarium. She was discharged to Hopemont under court order on June 29, 1964.

The infant was immediately placed in an incubator. Physical examination was normal. Laboratory findings were as follows: Hemoglobin

Table 1

Blood Gas Studies on the Patient, Compared With Average Values for Normal Individuals

Blood Gas Studies	5-22-64	*Normal Values*
pCO_2	53.1 mm. Hg.	40 mm. Hg.
pH	7.387	7.440
pO_2	48.0 mm. Hg.	94 mm. Hg.
O_2 Saturation	81.3 per cent	98 per cent

16.0 Gm., hematocrit 50 vol. per cent, WBC 9,100 with a normal differential. Chest films were normal. Gastric aspiration cultures were negative for AFB. Both Tine and IPPD skin tests were negative.

The infant's progress was normal until he was 10 days of age when his nasal mucous membranes became congested. Cultures revealed a nonpathogenic strain of Escherichia coli and Streptococcus haemolyticus. This condition responded well to Tetracycline 20 mg. b.i.d. for 11 days. On July 7, 1964, at 22 days of age, hemoglobin was 12.4 Gm., hematocrit 37 vol. per cent, and WBC 13,000 with a normal differential. The subsequent course was that of a normal premature infant. He was discharged at 27 days of age to the care of the maternal grandmother with supervision of the Child Welfare Department. His weight on discharge was 2,500 Gm.

Discussion

Numerous investigators have measured pulmonary functions of pregnant women. Cugell[1] et al reported that in normal pregnant women there is no defect of intrapulmonary gaseous distribution, but there is a decreased functional residual capacity and an increased ventilatory demand. In normal pregnant individuals in whose cases dyspnea develops, however, there is no correlation between alterations of pulmonary function and the severity of dyspnea.[1]

In patients with severe pulmonary insufficiency, ventilation is increased primarily by an increase of the respiratory rate.[2] Although this caused a disadvantageous alveolar ventilation-total ventilation ratio, it is a more economical way of increasing aeration for patients with greatly diminished lung volume.[2] This patient had an increase in respiratory rate averaging 20 per minute and was dyspneic and orthopneic. How much of this is due to the markedly decreased pulmonary volume and the degree of accentuation due to the congestive heart failure is unknown.

Numerous experiments involving blood gas studies of the normal mother, fetus and the placenta are found in the literature.[3,4,5,6] The pO_2 of normal maternal arterial blood has been determined to be in the range of 95 to 100 mm. Hg.[5,7] Furthermore, the normal intervillous blood pO_2 is approximately 35 mm. Hg.,[5] with a gradient of oxygen tension across the placental barrier to the order of 20 mm. Hg.[3,4,6]

This patient had a hemoglobin ranging from 9.5 to 10.5 Gm. per cent with only approximately two-thirds of her right lung functioning. It is not surprising, therefore, that her arterial pO_2 was only 48 mm. Hg. (1/2 of normal). On theoretical grounds it would appear that intrauterine life could not be sustained when a normal oxygen gradient is expected to be 20 mm. Hg. In spite of this, a normal viable male infant was delivered and survived.

Prystowsky[6] believes that survival of the fetus is accomplished by adjusting the oxygen tension to appropriate levels and maintaining them at all times despite changes in the material oxygen supply to the uterus. The mechanism of this regulation is not known at present.

The pH here would be considered normal due to compensation by the mother. The pCO_2 of 53.1 mm. Hg. probably is due to decreased lung volume. The infant was apparently not seriously affected by the low maternal pO_2 nor the high maternal pCO_2 as might be evidenced by the development of congenital anomalies. The major deficiency was exemplified only by poor development and apparent small size (1,800 Gm.) which may have been due both to the emaciating pulmonary disease and poor nutritional status of the mother.

The fetal hemoglobin was not as high as one might expect with a low maternal pO_2. It was instead low for the newborn (16 Gm. per cent). The future development and health of this infant can be expected to be normal provided an adequate environment is maintained. The prognosis for the mother is grave, primarily because of her severe pulmonary tuberculosis but also due to her lack of insight concerning her disease process.

Summary

A case of severe pulmonary tuberculosis, postpneumonectomy, with severe residual lung disease, in which the patient was delivered of a viable infant is reported. The infant was normally developed, with no congenital defects. Its size (1,800 Gm.) was due, in all probability, both to the poor nutritional state and severe pulmonary disease in the mother. The infant survived intrauterine life in spite of a pO_2 of only 48 mm. Hg. which normally requires a maternal

arterial pO_2 of 95 to 100 mm. Hg. to maintain intervillous pO_2 of 35 mm. Hg. Fetal hemoglobin at birth was only 16.0 Gm. per cent which to our minds was unexpected. The child developed normally after birth and was discharged in good health. The prognosis for the child is excellent while that for the mother is extremely guarded.

References

1. Cugell, D. W., Frank, N. R., Gaensler, E. A. & Badger, T. L.: Pulmonary Function in Pregnancy, Am. Rev. Tubere. 67:568-597, 1953.
2. Gaensler, E. A., Patton, W. E., Verstraeten, J. M. & Badger, T. L.: Pulmonary Function in Pregnaney, Am. Rev. Tubere. 67:779-797, 1953.
3. Hertig, A. T.: The Placenta: Some New Knowledge About an Old Organ, Obst. & Gynec. 20:859-866, 1962.
4. Prystowsky, H., Hellegers, A. & Bruns, P.: Fetal Blood Studies. Part XVIII—Supplementary Observations on the Oxygen Pressure Gradient Between the Maternal and Fetal Blood in Humans, Surg., Gynec. & Obst. 110-495, 1960.
5. Vasicka, A., Quilligan, E. J., Azner, R., Lipsitz, P. J. & Bloor, B. M.: Oxygen Tension in Maternal and Fetal Blood, Amniotic Fluid and Cerebrospinal Fluid of the Mother and Baby, Am. J. Obst. & Gynec. 79:1041, 1960.
6. Prystowsky, H.: Physiology of the Placenta, Ann. Rev. Med. 12:281-288, 1961.
7. Darling, A. C., Smith, C. A., Asmussen, E. & Cohen, F.: Some Properties of Human Fetal and Maternal Blood, J. Clin. Invest. 20:739-747, 1941.

Anniversary of a Blessed Release

THIS year marks the tenth anniversary of the completion of the field trials of the Salk vaccine, at which time this material was declared to be "safe, effective and potent."

With the start of mass vaccinations in 1955, the incidence of poliomyelitis for the first time turned downward, slowly at first but with increasing momentum as more children received the vaccine. A dramatic drop of 97 per cent has marked the incidence of poliomyelitis since 1955. During 1964 only 121 cases of poliomyelitis were reported for the whole country, a rate of less than 1 per million of population.

Many of us who came to medical maturity before the development of this immunization remember with horror the polio wards in our hospitals—the drone of the respirators, the frantic early morning call for emergency tracheostomy to stave off death from asphyxiation, and in talking with relatives, the hope abandoned.

This is a milestone we have passed. The desolation and frustration of the polio ward no longer exist. Thanks to the long and painstaking work of Enders, Salk, and Sabin, this tiger has been caged. It will be caged only so long as everyone of polio-susceptible age is immunized. This is something that concerns not only public health authorities but also every single practicing physician. He and he alone must constitute himself as a public health authority and personally see to it that everyone within his practice who should be immunized against poliomyelitis is so protected.

The art of medicine is long—the science is short but lengthening. Already we have turned to other fields to conquer. This exciting medical age, in which acute infection, poliomyelitis, diabetes, and replacement of tissue have one by one fallen to science, leads us on to greater efforts and, hopefully, greater accomplishments.—New York State Journal of Medicine.

Present State of Isotope Procedures

George G. Green, M. D.

WHOLEY, in 1959, published in this Journal a description of the common radioisotope procedures then in general use in clinical radioisotope departments. During the intervening years there have been changes in some of the more common procedures and a number of new uses have been developed. The purpose of this paper is to bring the report of the clinical uses of radioisotopes up to date and to comment on some of the research procedures not yet in general clinical use.

Radioisotopes in Diagnosis

Thyroid Diseases.—Concentration of radioactive iodine (I^{131}) or thyroid uptake continues to be one of the most valuable diagnostic aids. Uptake varies from one laboratory to another, but ranges below 15 per cent may be considered hypothyroid, those from 15 per cent to 50 per cent euthyroid, and those from 35 to 90 per cent or over, hyperthyroid. Obviously there is an overlap of the values, and determination of the protein bound radioactive iodine (PBI^{131}) helps to differentiate the euthyroid from the hyperthyroid patient. The PBI^{131} is separated from inorganic I^{131} and the radioactivity measured. PBI^{131} evaluation at 24 hours is called conversion ratio relating the PBI^{131} to PBI^{131} plus inorganic I^{131}; values over 50 per cent are considered hyperthyroid. At 72 hours, PBI^{131} is compared with the dose given and values over 0.27 per cent per liter of plasma indicate hyperthyroidism.

Urinary excretion of I^{131} bears an inverse relation to the thyroid uptake. At times, such as after thyroidectomy or in an acutely ill patient, its evaluation is of use. An uncollected specimen or the presence of renal disease may invalidate the results.

T-3 studies or T-3 Trisorb (in vitro tri-iodothyronine I^{131}) indirectly measures thyroid function. This is of value in those cases in which uptake studies fail because of recent iodide medication, but other medications and pregnancy may alter the values even in this procedure.

Many modifications of these tests are available when indicated to help clarify the clinical status of the thyroid problem.

Submitted to the Publication Committee, December 7, 1964.

The Author

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Hematological Studies.—In a busy general hospital blood volume determinations become a frequent procedure. Here, based on the dilution principle, I^{131} in the form of Risa (radioiodinated serum albumin human) is injected intravenously and the radioactivity of the blood after injection is compared with the radioactivity injected to find the blood volume or the amount of dilution of the radioactivity. Using the same principle, red blood cells are tagged with radioactive chromium (Cr^{51}) and injected intravenously. From the red blood cell dilution the red blood cell volume or mass is determined. Plasma volume also may be determined using Risa I^{131}.

Red blood cell survival studies require tagging of red blood cells, usually with Cr^{51}, and comparing radioactivity of the blood at intervals to determine the rate of disappearance of the tagged red blood cells. This may help in differentiating some of the anemias such as hemolytic anemia.

Iron metabolism is traced using radioactive iron (Fe^{59}). After intravenous injection the disappearance time of radioactivity from the plasma is related to iron stores or body need. Many important facts including red blood cell survival, blood volume, red cell volume, plasma volume, daily hemoglobin formation and erythrocyte utilization may be related to the clinical problem at hand. Modification of this by oral route may give information about the intestinal transport of iron.

Gastrointestinal Studies.—The Schilling test helps differentiate pernicious anemia from malabsorption syndrome. Cobalt-labelled Vitamin B 12 requires intrinsic factor from the stomach for absorption. Lack of this factor in pernicious anemia, or after gastrectomy, results in decreased absorption of B 12. If, after repeating the test using exogenous intrinsic factor, low absorption of B 12 persists, malabsorption syndrome should be suspected.

Fat studies are used in further differentiating pancreatic disease from malabsorption syndrome. Neutral fat requires enzymes from the pancreas for intestinal transport whereas fatty acids may be absorbed without pancreatic function. If there is low absorption of I^{131}—labelled neutral fats and fatty acids, then malabsorption syndrome is a distinct possibility.

Gastrointestinal blood loss can be evaluated by tagging red blood cells with Cr^{51} and examining the stools for radioactivity. This may be used to actually quantitate the blood loss.

"Exudative enteropathy," a condition of protein loss into the gastrointestinal tract, may be one of the more obscure causes of hypoproteinemia, as may be found in Menetrier's syndrome. I^{131}—labelled polyvinyl-pyrollidone (PVP) may be used to exclude this problem by examining the stools for radioactivity after intravenous injection of I^{131} PVP.

Liver Function.—I^{131}—labelled bengal rose is selectively excreted by the polygonal cells of the liver. Intravenous injection of I^{131} bengal rose may be used to evaluate liver function and even the patency of the biliary system by measuring the time required for the liver to extract the radioactivity from the blood and transfer it into the gastrointestinal tract. Scanning with I^{131} bengal rose or colloidal gold ^{198} actually helps to map out areas of nonfunction secondary to abscesses, metastases, or any space occupying mass.

Kidney Function.—Hippuran I^{131} now seems to be the more widely used isotope as a screening procedure to evaluate renal blood flow and renal function. Chlormedrin $Hg.^{203}$ and Chlormedrin $Hg.^{197}$ are becoming more extensively used as scanning agents for localizing areas of impaired excretion such as may be found associated with a space occupying mass, impaired blood supply, or nonfunction.

Pulmonary Function.—Pulmonary function studies, employing radioactive inert gasses such as $Krypton^{85}$ are less widely used, mainly because of the special equipment and closed systems needed to avoid radioactive contamination. Pulmonary scanning, while still in the experimental phase, has promise especially in localizing pulmonary infarction. I^{131} compounds of larger molecular size are used so as to demonstrate these areas of impaired blood supply.

Circulation Studies.—There are almost limitless applications of isotopes in evaluating the dynamics of circulation. Details of the many procedures are too extensive to record here but are readily available in other publications. Some of the many procedures include determination of blood flow between two points, cardiac output, coronary artery blood flow, localization of myocardial infarct, liver blood flow, placental localization, detection of pericardial effusion, adequacy of circulation in bone or tissues and cardiac shunt.

Scanning Procedures.—Thyroid scanning, one of the first in use, continues to be of value especially in the study of thyroid nodules.

Brain, kidney, liver and spleen scanning are being employed with increasing frequency.

The brain scan in many institutions is being used as a survey study in suspected brain tumor since it may be performed without morbidity and on an outpatient basis. Scanning, however, does not replace the conventional pneumoencephalography or arteriography but at times may demonstrate localization of a brain infarct in the acute stage even when angiography apparently is normal. Brain scan actually may give a positive image of the tumor, better delineating its size and location.

Other scanning areas less widely examined at this time include the lungs for pulmonary infarction, the heart for pericardial effusion, the pancreas for tumor, and bones for metastases.

Research Diagnostic Studies

Body Water and Electrolytes.—Studies of this nature, while employing the same basic principles as the other isotope procedures, require equipment of a special nature such as liquid scintillation counters, windowless gas flow counters, automatic sample changers and fraction collectors.

Body water and electrolytes including sodium, potassium, chlorides, calcium and magnesium may be evaluated but most of the general isotope departments are not equipped for these procedures.

Activation Analysis.—Analysis of the composition of human tissue is possible by the isotope method. The tissue in question is made radioactive and by identification of these radioactive isotopes, the composition of the unknown is determined both qualitatively and quantitatively.

Such a study as this, while most interesting, is not readily accomplished since it requires an activator source to make the tissue radioactive.

Radioisotopes in Therapy

Treatment of the thyroid gland continues to be one of the main therapeutic applications of radioactive isotopes. Hyperthyroidism including Grave's disease and toxic nodular goiter are amenable to isotope therapy. The response of diffuse

goiter continues to be more reliable than that of the toxic nodular goiter. Most departments still refrain from I^{131} therapy for hyperthyroidism below the age of 40 years unless there is a recurrent post-thyroidectomy or a medical contraindication for surgery.

The euthyroid-cardiac patients most frequently referred for I^{131} therapy are those with stabilized but intractable angina or congestive failure, or both, who have resisted all usual forms of therapy.

Treatment of thyroid cancer with I^{131} is never curative but in some instances, especially the well differentiated carcinomas with thyroid function, palliative therapy can be quite effective. Thus all patients should first receive the maximal benefit that can be afforded by surgery before consideration of isotope therapy.

Radioactive phosphorous in the form of P^{32} has found continued use in the therapy of polycythemia, the leukemias and the malignant lymphomas. The relatively selective localization of P^{32} in the hematopoietic tissues makes this a valuable adjunct to other forms of therapy for these diseases.

Colloidal P^{32} or colloidal Au^{198} injected into the pleural or peritoneal space continues to be of value in reducing excess fluid formation secondary to metastases, but the tumor masses should still be managed by surgery or x-ray therapy, or both.

Radioactive colloids injected directly into tumor tissue still finds some proponents but in general the method is not widely used nor recommended.

Telecobalt therapy or other isotopes such as radioactive strontium (Sr^{90}) are widely used and are an accepted form of therapy. Details of their use and indications are beyond the scope of this paper.

Acknowledgment

The author wishes to express his appreciation to Dr. Harold I. Amory and Dr. Clement A. Smith, who kindly reviewed the contents of this article.

References

1. Wholey, M. H.: An Introduction to Radioisotopes, West Virginia M. J. 55:264-269, (Aug.) 1959.
2. Hayter, C. J.: Radioactive Isotopes in Medicine. A Review. J. Clin. Path. 13:369-390 (Sept.) 1960.
3. Loh, W. P.: Diagnostic Uses of Radioisotopes. J. Indiana Med. Assoc. 53:2209-10 (Dec.) 1960.
4. Loh, W. P.: Present Status of Radioisotopes in Clinical Medicine, J. Indiana Med. Assoc. 54:618-24 (May) 1961.
5. Myerson, R. M., Wohl, G. T. & Rabinowitz, J. L.: Use of Radioisotopes for Diagnostic Purposes, M. Clin. North America 45:1655-1661 (Nov.) 1961.
6. Ogborn, R. E.: Practical Isotope Technics in Clinical Medicine, South Dakota J. Med. & Pharm. 15:105-108 (March) 1961.
7. Owen, C. A., Jr.: Diagnostic Use of Radioisotopes, Arizona Med. 19:19-25 (Feb.) 1962.
8. Silver, S.: Radioactive Isotopes in Medicine and Biology, Medicine, ed. 2, Philadelphia, Lea & Febiger, 1962.

Greatest Good for the Greatest Number

EACH drug, new or old must be examined in the light of the statistical probabilities of its capacity for effective treatment and its capacity for toxicity. The problems are enormous. Should aspirin, producing a 60 to 70 per cent incidence of gastrointestinal hemorrhages and an estimated 500 deaths per year but saving no lives, be permitted? Should a drug responsible for saving 150,000 lives per year and simultaneously responsible for 500 deaths be permitted? There can be no general rules; each situation is a problem to be examined in and of itself; decisions must be made upon a basis of scientific humanism: scientific in the sense that the morality and ethics of impact (the greatest good for the greatest number) is the motivation.—Gustav J. Martin, ScD, in Experimental Medicine and Surgery.

Special Article

Children's Heritage to Health*

Jay M. Arena, M. D.

CHILDREN under 15 years of age now constitute approximately 30 per cent of the total population. Their heritage of health can best be ascertained from the following report of:

Childhood Deaths—Accidents vs. Disease Ages 1-14 for 1960

Cause of Death	*Number*	*Per Cent*
All Causes	33,546	100
Accidents	11,402	33
Cancer	4,138	12
Congenital Malformation	3,257	9
Pneumonia	3,071	8
Heart Disease	681	2
All Others	10,997	36

*Source-Accident Facts 1961, National Safety Council, 1961.

Four important facts are readily derived from the above table:

(1) Accidents are the largest single cause of death in the childhood age group (1-14 years).

(2) One out of every 3 children who die, dies of an accident.

(3) Accidents kill more children than the four leading fatal diseases combined.

(4) Paradoxically, the most significant factor appears to receive the least emphasis.

Accidents in the Home

Contrary to popular belief, the majority of accidents involving children occur at home. The American home is fast becoming a hazard instead of a haven. One typical survey of a hospital emergency room service revealed that approximately 3 of every 4 childhood injuries treated at this facility originated in the home. Similar estimates from other sources vary, but 60 per cent can be regarded as a reasonably accurate average.

Children are naturally inquisitive. They learn by exploration, sampling, questioning, imitating and trial and error. Maximum exposure to numerous potential hazards, household agents (over 250,000 of them) and miniature bathroom drug stores account for the huge percentage of toddler home accidents and poisoning. With increasing age, development, diversification of exposures and other important factors, however, the older child experiences less difficulty at home, as well as less mortality and morbidity from all forms of accidents.

Although basic precautions should be taken, the home cannot be made totally accident proof. It is inevitable that our children be constantly exposed to these potential dangers. To deny the existence of these hazards is unrealistic; to create an artificial environment without danger is impractical and impossible. During infancy, parental and environmental protection is mandatory.

As the infant progresses through the various stages of growth and maturation, crawling, pulling up, walking, climbing, exploring, etc., parental omnipresence ceases to guarantee safety. The importance of recognizing that a child is a constantly changing organism with increasing capacities and capabilities in shifting environmental influences cannot be over emphasized.

Accidents do not "just happen"; they are caused by a sequence of events. Parents, especially mothers, must be made aware of the factors that produce them and learn how to prevent them.

Passive protection is not enough. It is necessary for the child to learn to understand the risks he runs. Adults frequently make one of two mistakes: either they credit the child with more intelligence than he possesses, or they assume he is quite unable to think for himself. In both cases they fail to understand that they are

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*Presented before a meeting of the Harrison County Medical Society in Clarksburg on April 1, 1965.

dealing with a mind and body in constant development.

Educating the Child

Between 12 and 15 months, the child is absorbed in examining the world around him. He will explore the house. He will try to touch everything he comes across, particularly if it is on a level with his eyes. He will try to put almost everything into his mouth, sampling anything regardless of its taste, substance or repulsiveness. Around two, he becomes capable of opening a door. He likes to lift up a lid and empty a box, only to fill it up again afterwards. He has little idea of distance and tries to climb here, there and everywhere. To play with water becomes a favorite pastime. At about three, he is surer of his movements and likes to go walking. He learns to distinguish right and left. He enjoys feeling responsible and making himself useful. At the age of four, he thinks of nothing but running about and playing ball. He can ride a tricycle and climb trees. He can concentrate mentally for longer periods.

Accordingly, safety education should be pursued along three lines:

1. Teach the child to distinguish between the risks he may take and those he had better avoid.
2. Teach him the best way of dealing with the dangers that he cannot absolutely escape.
3. Teach him the discipline of obedience. Discipline is not synonymous with punishment. Discipline is setting limits on behavior and maintaining these limits through education, parental example, encouragement, cooperation, insistence, temporary isolation if necessary, and sometimes punishment.

Stresses and Pressures Associated With Childhood Accidents

If parents are to provide their children with a judicious blend of advice, reprimand and prohibition, they must learn to know themselves and their children better. They should, for instance, be familiar not only with the manifold and complex problems responsible for home accidents, but also the additional allied strains and stresses such as those reported from a survey in Sweden and recently from the Children's Hospital Medical Center in Boston, that bring them about. The surveys showed the following stresses and pressures associated with childhood accidents:

1. Hunger or fatigue, particularly during the hour before a scheduled meal during late afternoon, or before bedtime (75.5 per cent of children).
2. Hyperactivity (62 per cent of children).
3. Parental lack of understanding of what to expect at various stages in childhood development (87 per cent of parents).
4. Illness, pregnancy, or menstruation of the mother (54 per cent of mothers).
5. Recent substitution of person caring for the child, as from mother to sister (54 per cent of children).
6. Continually tense relationship between parents (44 per cent of families).
7. Illness or death of other family members, taking most of the mother's attention (35 per cent of accident families).
8. Sudden change of child's environment, as in moving or at vacation time (16 per cent of families).
9. Mother is rushed or too busy; Saturday is the worst accident day, particularly from 3 to 6 P.M.

Safety Suggestions for the Child

The following child safety suggestions can protect the lives of children if they become the rules of every parent. The medical profession and safety organizations should assume the responsibility of teaching young parents these important facts:

1. Baby proof your home by removing booby traps.
2. Ask what you would need to do if you were going to leave your child alone for *one* hour.
3. Children want to obey and expect the leadership of rules.
4. Tell the truth.
5. Ration your commands.
6. Enforce your commands.
7. Be consistent.
8. Agree on commands.
9. Punish the child in some appropriate manner when he violates obedience rules.
10. Don't set goals too high to reach.
11. Forbid dangerous games, tricks, sports. Have your child taught to swim at an early age.
12. Reward obedience.
13. Make sure children understand your meanings.
14. Make cars safe inside.
15. Drive safely to make them safe outside.
16. Love and enjoy your children. Their response is effective discipline.

Prevention of Poisoning

The prevention of poisoning requires a somewhat different approach than is generally necessary for the prevention of other types of accidents. Here the age group of children most frequently involved is under five years, and it is easier to alter their physical environment and make it safe for them.

The following preventive measures, among others, are needed and worth striving for:

(1) Enforcement of the Uniform Hazardous Substance Act. This Federal law was enacted on July 12, 1960. It requires that hazardous household products bear information to protect users and to warn against accidental ingestion by children. The law requires labeling to include the common, usual or chemical name of the hazardous substance, the single word "Poison," "Danger," "Warning" or "Caution" depending on the chemical's potential and degree of toxicity. Also required is an affirmative statement of the principal hazard or hazards, such as "Flammable," "Vapor Harmful," "Causes Burns,"

etc.; precautionary measures describing the action to be taken or avoided; instruction, when necessary or appropriate, for first-aid treatment; and finally, the statement "Keep out of reach of children," or its practical equivalent.

(2) Use of effective safety closures for drugs and poisonous household agents by the drug and chemical industries. Some children will at times circumvent any and all precautionary measures yet, for each child successful in removing a grip-tight cap or similar safety device, there will be many who would be unable to do so.

(3) Education of laymen, and particularly manufacturers, to their responsibility to the public health and safety of all products.

(4) Drugs should be received by children seriously and with a matter of fact attitude. The giving should not be made a game. Drugs should never be referred to as *candy* and children should never be bribed by such inducements. Parents, and especially those taking medications or vitamins regularly, should take their pills and elixirs in privacy and not in the presence of small children. They are great imitators.

(5) Preventive and educational efforts by physicians, nurses and community organizations at the local level often accomplish more than well-published advisory measures on a national scale.

(6) Establishment of more and properly functioning Poison Control Centers. These centers perform a vital public health service. This problem, however, shall never be eliminated unless parents and those responsible for the care of small children create their own poison control center at home. To prevent tragic poisoning accidents, children must be protected. This can only be done by a responsible parent or individual educated and personally aware of the potential dangers that can be encountered in each and every room, for the growing inquisitive child.

Naturally!

WHAT would you do if you had a patient referred to you complaining of a recent episode of sudden and severe pain in the epigastrium which caused faintness and a cold sweat, with a residual and persistent epigastric pain? And suppose that this patient had had a KUB, an intravenous pyelogram, stomach and gallbladder x-rays but five weeks before, and the findings all had been negative. Suppose, too, that the physical examination revealed a normal cardiovascular system and only a mild upper abdominal tenderness.

Naturally you would order the routine laboratory tests, a serum amylase, a chest x-ray and a scout film of the abdomen. But what if these were all essentially normal? Well, you might then do a barium enema preceded by a proctoscopic examination, for surely the colon approaches the epigastrium somewhere along the way. Strange things can happen and it wouldn't do to overlook any tests. But what if these revealed no abnormalities except for a few small hemorrhoids?

To compound the problem, suppose that you notice one day during your morning rounds that the patient was calmly reading the daily newspaper, though he continued to insist on almost constant suffering from the epigastic pain. Well you would doubtless now be in a position where you would have to sit down and take a careful history, and maybe do a little thinking too. But if all this only turned up some rather irrelevant facts and irrelevant thoughts?

We are coming now to the point of the story. Naturally you remember the old adage: "Never operate just for pain." But an adage always seems to be of greatest value after the fact, so adage or no adage, you would be very likely to operate. And what would your pre-operative diagnosis be? Well, naturally, it would have to be something pretty vague, such as "exploratory laparotomy." And what would you find? A toothpick perforating the stomach wall—naturally!—Daniel F. Crowley, Jr., M.D., in Journal of the Iowa Medical Society.

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Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

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Each tablet and each 5 cc. of liquid contains:

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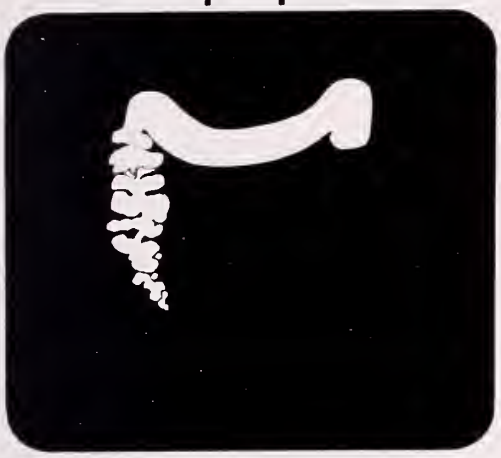

relieves distress

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Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

The President's Page

Let us have faith, that right makes might,
And in that faith, let us to the very end,
Dare to do our duty as we understand it.

ABRAHAM LINCOLN

THIS year's annual meeting at The Greenbrier with Dr. James Z. Appel, President of the American Medical Association; Dr. Walter H. Judd, Keynote Convention Speaker, Medical Missionary and former Congressman; and Dr. Edward R. Annis, Past President of the American Medical Association and medicine's voice in this epic struggle with Congress; should be one of the most memorable conventions in many years. The roster of scientific speakers is equally as impressive and with the important decisions to be made by your House of Delegates on many matters, I urge each of you to complete your reservations for The Greenbrier in August at once. I hope that I shall see you there personally.

While in Washington this past month, we were told, frankly, that the socialistic planners are saying that the doctors are losing their willingness to fight, that we are tired and want to give up the fight and get it over with—and they plan on the worst to come and, as they have said, they need win only once.

With the Senate Finance Committee adding amendments to H.R. 6675 (the Mills Bill), it will need to pass the Senate and possibly be amended further there, then it will go to the Senate-House Conference Committee to try to iron out these differences. From there, it will then go back to the House of Representatives for another vote. As you recall, we lost by only 23 votes in the House the last time the bill was there—*less than one Representative from each State.* Can we unite in this last massive fight to inform the American people and our State's Congressmen and Senators of the bill's inequities and ask them to vote against this monstrous socialistic scheme? Its effect on the quality of medical care by the placing of a third party in the traditional patient-physician relationship; its total disregard of catastrophic illness of the aged which should have been a major consideration and is covered under Kerr-Mills; its effect on the general economy of the country with a six billion dollar price tag for the first year of operation; and its economic effect on the young worker and his take-home pay and its devastating effect on the health care of our remaining entire population plus socializing an entire profession-medicine, must give our Representatives and Senators much concern. Sir Winston Churchill in describing Socialism said: "Socialism is the philosophy of failure, the creed of ignorance and the gospel of envy . . . Socialism will work only in two places—in Heaven, where it is not needed, and in Hell, where they already have it."

Your aid now will be worth many, many words and deeds later. Write your Congressmen and Senators and tell your patients our true story. This is *really* the time for action.

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

WELCOME TO OUR NEW ADVERTISERS

Since 1961 there has been a steady decline in the amount of national advertising placed in our State Journal. Many drug houses that use national or "throw away" journals do not believe in the efficacy of local advertising. One such company with a recent nine-page spread in the *JAMA* has not used *The West Virginia Medical Journal* for many years.

It is comforting to know there has been a recent upsurge in the amount of advertising received for publication in *The West Virginia Medical Journal.*

This month we welcome to *The Journal* Lakeside Laboratories of Milwaukee, Wisconsin, which has given us the largest contract we have received in many years. This nine-page spread will continue for at least six months. Lakeside is a highly ethical proprietary drug house and its invasion of the South, we hope, will meet with favorable response and success.

Milan Pharmaceuticals began a unique advertising display in the June *Journal* and other new advertisers or advertisers returning after absences include Armour Laboratories; Hynson, Westcott and Dunning; J. B. Roerig; Procter and Gamble; McDonough-Caperton-Shepherd-Goldsmith, administrators of our group insurance plans; and Physicians Nationwide Inc. Also, you will note that G. D. Searle has enlarged its advertising schedule effective with this issue.

We hope those drug companies which dropped State Journal advertising in 1964 and 1965 will return to the fold this year.

A listing of our advertisers is always found on the left inside back cover of *The Journal.* They are the people who supply the money to keep *The Journal* in circulation. *The Journal* is interested in promoting more local advertising, but most of this work will have to come from local groups or component societies.

Whatever medical convention you may attend you are constantly importuned to visit and show courtesy to the exhibitors who supply the financial sinews of the meeting. In all medical journals the plea is the same. We hope you believe in the old dictum: "Other things being equal, we do business with our friends."

NEEDED: ACCIDENT PREVENTION PROGRAM FOR CHILDREN

Elsewhere in this issue of *The Journal* there appears an article concerning children's accidents written by a native West Virginian, Dr. Jay M. Arena of the Duke University School of Medicine.

The information contained in Doctor Arena's article is startling. To children under 15 years or 30 per cent of our population, accidents cause 11,000 deaths per annum. This exceeds the total of the next four leading causes of death; specifically, cancer, congenital diseases, pneumonia and heart disease. There are major public health or voluntary health programs directed against these other ailments but little is said or done in the matter of accident prevention.

Most of the fatal accidents occur within the home, and insofar as foreseeable prevention is concerned, must be a familial responsibility. Certainly, a high percentage of these accidents may be prevented through better parent-child understanding. There is no field in public health or private medicine where more direct and rewarding results may be obtained than in this field of accident prevention. It could well become a campaign of medical, educational, religious bodies and PTA organizations. Some of the voluntary health organizations, whose aims have been partially achieved, might turn to accident prevention as a new field of health endeavor. In West Virginia no child died of polio in 1964 but 137 children under 15 died of non-transport accidents and 56 of these fatalities occurred in the home. The most common sources of trouble were fire and suffocation. According to the vital statistics of the State Health Department, there has been some variation but little statistical change in the child mortality rate in the past 5 years.

One field of dangerous drug poisoning that is preventable is in the self-dosage and family prescribing of aspirin. An article by Dr. Alan K. Done in the May 31 issue of the *JAMA* condemns the indiscriminate use of aspirin in children.

"The most severe instances of aspirin poisoning among young children result from therapeutic overdosage," Doctor Done wrote.

Giving aspirin every four hours to a young child can result in gradual accummulation to toxic levels and these dangers are enhanced greatly when flavored aspirin is used.

The family bathroom closet with its array of aspirin, headache powders, laxatives, sleeping pills, suppositories and whatnot should be looked and it has been recommended that it contain a 1 oz. bottle of syrup ipecac—a harmless but useful emetic for almost all ingested poisons. Given as soon as the accident is discovered, it will induce vomiting before the doctor arrives or the child can reach the emergency room.

For complete information on all manner of home accidents, readers are referred to Today's Health Guide, a new publication of the AMA. This book is designed for guidance of the family in all health activities. It is written for non-medical people by 200 outstanding physicians and health experts. The chapter on "Safety in the Home" is excellent and provides information on all the common causes of death and accident in the home.

There also are many excellent articles and pamphlets concerning cause and prevention of childhood accidents which are available from the Superintendent of Documents of the United States Government.

Reprints of Doctor Arena's article are available upon request to *The West Virginia Medical Journal*, Box 1031, Charleston, West Virginia 25324.

CONTROL OF TUBERCULOSIS

In 1963 the House Appropriations Committee expressed concern about the effectiveness of tuberculosis control programs in the United States and suggested that the Surgeon General form a Task Force on Tuberculosis Control to consider the current situation and to recommend improvements of the "present unsatisfactory situation."[1] The findings and recommendations were published in December, 1963.

1. The Task Force Report:

The report highlighted the tuberculosis problem in the United States, bringing these problems to the forefront—to Congress, the press and workers in local communities.

The scope of the tuberculosis problem in the United States in 1962 was emphasized by estimates of 35 million persons infected with the tubercle bacillus and of 610,000 persons needing tuberculosis care or follow up. The geographic distribution of tuberculosis is very uneven; in 1962 nine areas totaling less than 16 per cent of the U. S. population reported 27 per cent of the total cases of tuberculosis. Twenty per cent of tuberculosis cases were less than 25 years of age and over 50 per cent were 45 or older. Males predominated (65 per cent) except in the younger age groups where females led.

With a positive skin test reaction risk of disease is higher in young children and young adults, in persons with diabetes or silicosis, in persons receiving corticosteroid therapy, and in persons with abnormal shadows on chest x-ray. With a negative skin test reaction the risk of developing tuberculosis is higher in persons in contact with an individual with communicable tuberculosis, the risk increasing with the closeness of contact.

The report emphasized a need for services and highlighted the changing trend to therapy outside of a hospital, necessitating increased facilities for clinics, nursing services, home care programs, etc. The need for improvement of case finding methods was noted.

Tuberculosis is communicable and is spread from person to person by the airborne route. This is an important point, for it is the weak link of the chain and offers opportunities for control and prevention of tuberculosis.

The Task Force recommendations for improvement of control of tuberculosis provided for:

- Services for adequate treatment—in and out of hospital.
- Follow-up of patients for five years (or life).
- Examination and prophylactic treatment of families and close contacts of patients.
- Skin testing of children entering school and x-rays of all positive reactors.
- Follow-up all reactors in children to home, school, and other sources looking for contacts.
- Annual skin tests for teachers and other personnel.
- Repeat skin tests of children at age 14 or 7th grade with follow-up.
- Screen high risk groups.
- Maintain proper records and cooperate in exchange of information between agencies.

Based on the 1962 figure of 63,400 active cases in the United States, it was estimated that current programs would bring a reduction to 50,700 cases in 1972. The Task Force program, if adopted, is estimated to reduce the cases to 22,000 by 1972.

2. Applications to West Virginia.

In 1964 there were 3,233 cases of tuberculosis on the active register in West Virginia. Of these 658 were in sanatoria and 2,575 were at home. Six hundred and eighty new cases were listed, and 115 deaths due to tuberculosis occurred.[2] Data are not available for comparative 1964 figures, but in 1962 West Virginia ranked 14th in the nation by case rate. (W. Va. 33.0/100,000, U. S. 28.7). West Virginia ranked 6th in the nation for tuberculosis death rates (W. Va. 8.1/100,000, U. S. 5.1).[3]

While a high rank is admirable in many situations, West Virginia should strive to be at the bottom of the list in this instance. Tuberculosis cases and deaths can be reduced drastically by following the Task Force recommendations. It can be done, but it will require cooperation between the medical profession, official and voluntary health agencies, and ultimately the entire State through programs of health education, case and contact finding, and treatment. Perhaps we should consider multiphasic programs, since a search for one disease uncovers many other types of diseases as well.—*(Guest Editorial by Ernest W. Chick, M. D., Chief of the Department of Public Health and Preventive Medicine, West Virginia University School of Medicine).*

1.a. The Future of Tuberculosis Control, A Report to the Surgeon General of the Public Health Service by a Task Force on Tuberculosis Control. Public Health Service Publication No. 1119, December, 1963.

b. Where Do We Go From Here? The TB Association in Tuberculosis Control Today, Implications of the Surgeon General's Task Force Report. National Tuberculosis Association, August, 1964.

2. West Virginia Tuberculosis Information, 1964, West Virginia State Department of Health.

3. Reported Tuberculosis Data, 1964 Edition. Public Health Service Publication No. 638.

Drug Advertising

Almost 600 new basic chemical and biological drugs were developed in the last 30 years. In spite of plant expansion, labor costs and research expenses, pharmaceutical prices have gone down 13.8 per cent since 1949 compared to a rise of 26.7 in the Wholesale Price Index of the Bureau of Labor Statistics.

Being acutely aware of the attacks on the American pharmaceutical industry by our national government and its committees, it is interesting to note that if all drug advertising were eliminated, it would amount to a saving of some 5 cents on a dollar for a prescription item. This is one of the major things the Kefauver committee was trying to do.

How the medical profession would be affected by such a restriction is hard to envisage and what it would do to the drug industry might well be catastrophic, unless, of course, the doctors were required to prescribe only from a government formulary as was tried by the government of Australia in 1949.—W. Albert Brewer, M. D., in Arizona Medicine.

Dire Effects of New Drug Laws

Several presidents of smaller companies have told me personally that they have abandoned all research efforts in the field of new drugs. They asserted that a small company cannot afford this type of research under the new regulations. And this is still an economy of free enterprise!

The larger companies have not been able to create and market new chemical compounds with the same degree of efficiency as prior to the passage of the new law. This results in a definite curtailment of the total health progress of the nation for several reasons.—John C. Krantz, Jr., Ph. D., in Military Medicine.

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 26-28

A prominent ophthalmologist from North Carolina and six members of the faculty of the West Virginia University School of Medicine have accepted invitations to present papers during the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Bernard Zimmermann, M. D.

N. W. B. Craythorne, M. D.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, announced that Dr. Samuel D. McPherson, Jr., Acting Chief of the Division of Ophthalmology at the University of North Carolina School of Medicine, will appear as a speaker at the second general scientific session on Friday morning, August 27. His subject will be "Some Ocular Signs of Systemic Disease."

Doctor McPherson also will present a paper on "The Surgical Treatment of Chronic Open Angle Glaucoma" before a meeting of the West Virginia Academy of Ophthalmology and Otolaryngology on Friday afternoon.

A native of Durham, Doctor McPherson was graduated from the University of North Carolina and received his M. D. degree in 1943 from the Johns Hopkins University School of Medicine. He served as House Officer, Assistant Resident and Resident Ophthalmologist to the Wilmer Institute of the Johns Hopkins Hospital, 1944-48.

He is currently serving as Chief of Staff at McPherson Hospital in Durham and has served since 1955 as Clinical Professor of Ophthalmology and Acting Chief of the Division of Ophthalmology at the University of North Carolina School of Medicine.

Doctor McPherson was certified by the American Board of Ophthalmology in 1948 and he is a Fellow of the American College of Surgeons and a member of the American Medical Association.

'WVU School of Medicine Day'

Six members of the West Virginia University School of Medicine faculty will participate in a Symposium on "Emergency Maintenance of Life" which will be held on Saturday morning, August 28. The speakers and their subjects are as follows:

N. W. B. Craythorne, M.D., Associate Professor and Chairman of the Division of Anesthesiology (Introductory Remarks).

Paul E. Huffington, M. D., Instructor in the Division of Anesthesiology. Subject: "Maintenance of the Airway."

Allen E. Yeakel, M. D., Associate Professor of Anesthesiology. Subject: "Respiratory Resuscitation."

Herbert E. Warden, M. D., Professor of Surgery. Subject: "Cardiovascular Resuscitation."

N. W. B. Craythorne, M. D. Subject: "The Pharmacological Aspects of Cardiac Arrest."

Alphonse C. Edmundowicz, M. D., Assistant Professor of Medicine. Subject: "Electrical Defibrillation of the Heart."

Bernard Zimmermann, M. D., Professor and Chairman of the Department of Surgery. Subject: "The Management of Crushed Chest."

Alphonse C. Edmundowicz, M. D. Subject: "The Management of Life-Threatening Arrhythmias."

There will be a 30-minute question and answer period following the presentation of formal papers.

Clinical Pathological Conference

An innovation at this year's meeting will be a Clinical Pathological Conference which will be held on Friday morning, following formal presentations by three guest speakers. Dr. Kenneth G. MacDonald of Charleston will serve as moderator.

Dr. Leon Schiff, Professor of Medicine, University of Cincinnati College of Medicine, will serve as the clinical discussant and the pathological and radiographic findings will be presented by Drs. Grover B. Swoyer of Charleston and a radiologist to be named later.

A protocol for the CPC will be inserted in a Convention Bulletin which will be mailed to all members of the State Medical Association prior to the meeting.

First General Session

The first general scientific session will be held on Thursday morning, August 26. The speakers and their subjects will be as follows:

R. Gordon Douglas, M. D., Emeritus Professor of Obstetrics and Gynecology, Cornell University Medical College, New York City; and Consultant in Obstetrics and Gynecology to the New York Hospital. Subject: "Amniocentesis and Intra-Uterine Transfusion in Rh Immunized Patients."

Thomas E. Shaffer, M. D., Professor of Pediatrics and Preventive Medicine, Ohio State University College of Medicine, Columbus; and Team Physician for Ohio State Athletic Teams. Subject: "The Adolescent Athlete."

Cornelius E. Sedgwick, M. D., Member of the General Surgery Staff, Lahey Clinic Foundation, Boston, Massachusetts. Subject: "Portal Hypertension."

Second General Session

The speakers at the second scientific session on Friday morning will be as follows:

William G. Thurman, M. D., Professor and Chairman of Pediatrics, University of Virginia School of Medicine, Charlottesville. Subject: "What to Do with the Bleeding Child."

Samuel D. McPherson, Jr., M. D., Acting Chief of the Division of Ophthalmology, University of North Carolina School of Medicine. Subject: "Some Ocular Signs of Systemic Disease."

Leon Schiff, M. D., Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Subject: "The Differential Diagnosis of Jaundice."

The Clinical Pathological Conference will be held immediately following the presentation of the paper by Doctor Schiff.

Honor Guests

Dr. Walter H. Judd, former Medical Missionary and Congressman from Minnesota, will be among the honor guests and will appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 26.

Dr. James Z. Appel of Lancaster, Pennsylvania, President of the American Medical Association, will speak before the first session of the House of Delegates on Wednesday afternoon, August 25.

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will deliver his Presidential Address before the second session of the House of Delegates on Saturday afternoon, August 28.

The number of reservations for rooms at The Greenbrier for the Annual Meeting in August has passed the 300 mark and it is anticipated that more than 700 persons, including physicians, their wives and guests will be in attendance.

All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The program for the Annual Meeting has been completed and it will be published in the August issue of *The Journal.*

W. Va. Allergy Society Plans Meeting At The Greenbrier on Aug. 26

Two out-of-state physicians have accepted invitations to present papers before a meeting of the West Virginia State Society of Allergy which will be held during the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Claude A. Frazier, M. D.

Dr. Merle S. Scherr of Charleston, Secretary of the Society, announced that the guest speakers on Thursday afternoon, August 26, will be Dr. Claude A. Frazier, a native West Virginian who now practices his specialty of allergy in Ashville, North Carolina, and Dr. Nathan Schaffer of East Orange, New Jersey.

Doctor Frazier, who is a member of the Editorial Board of *A Review of Allergy and Applied Immunology* and a past editor of the Allergy Section of the *Southern Medical Journal,* received his M. D. degree in 1944 from the Medical College of Virginia. He received his allergy training at the Roosevelt Hospital in New York City and was certified by the American Board of Pediatrics in 1952. He will present a paper on "Insect Sting Allergy and Its Management."

Doctor Shaffer, who will speak on "Modern Assessment of Therapy for Allergy Diseases—1965," received his M. D. degree in 1930 from the University of Michigan School of Medicine. He interned at University Hospital in Ann Arbor and served a residency at Newark Beth Israel Hospital in Newark, New Jersey.

Dr. Myer Bogarad of Weirton is President of the West Virginia State Society of Allergy and Dr. Marshall J. Carper of Charleston, Vice President.

Dr. C. A. Hoffman Reelected Treasurer of AUA

Dr. C. A. Hoffman of Huntington, a Past President of the West Virginia State Medical Association, was reelected Treasurer of the American Urological Association at the 60th Annual Meeting in New Orleans, May 9-13.

He is a Past President of the Mid-Atlantic Section of the AUA and served for several years as Chairman of the Public Relations Committee of the parent organization.

Doctor Hoffman is a member of the Board of Directors of the National Association of Blue Shield Plans and recently was named as a member of the Executive Committee. He has served since 1959 as one of the two West Virginia Delegates to the American Medical Association.

Spring Meeting of Council Held In Charleston on May 16

The Council of the West Virginia State Medical Association unanimously adopted three resolutions pertaining to health care for the aged legislation during the regular Spring meeting which was held at the Daniel Boone Hotel in Charleston on Sunday, May 16.

There was considerable discussion concerning HR 6675—the Medicare bill—which is now under consideration in Congress. The bill was passed by the House of Representatives and is now being studied by the Senate Finance Committee. It was expected that the bill would be brought to the floor of the Senate for a final vote early in July.

The resolutions adopted by the Council are as follows:

Subject: Preserving The Freedom and Quality of Patient Care

WHEREAS, A physician's first responsibility is to serve his patient to the best of his ability, and

WHEREAS, There is under consideration in Congress at this time H. R. 6675, a Medical Care for the Aged Bill, which if enacted as set forth would tend to produce compulsory hospitalization and control of hospital care and inferior and deteriorating quality of medical care for those people over the age of 65, and

NOW, THEREFORE BE IT RESOLVED, That physicians should be, and hereby are informed that under the terms of H. R. 6675 (Title XVIII—Health Insurance for the Aged, Sec. 1802), no physician is compelled to provide services under the provisions of the bill, and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association urges each physician to become familiar with the terms of H. R. 6675 and decide for himself whether he desires to provide services under the provisions of the bill, and

BE IT FURTHER RESOLVED, That whatever course each physician elects, he be mindful of his continuing responsibility to provide the best medical care to his patients, continuing the highest quality of medical care obtainable anywhere irrespective of ability to pay, in keeping with his professional principles and maintaining his patient-physician relationship, and

BE IT FURTHER RESOLVED, That we direct our delegates to the American Medical Association to promote at the 1965 Annual Convention in June the idea on a nationwide basis and that the physicians in West Virginia be informed of this action.

* * * *

Subject: Maintaining Professional Freedom

WHEREAS, The American Hospital Association and the National Blue Cross Plans include in their charges for hospital care, fees for professional medical services provided by radiologists, pathologists, anesthesiologists, and physiatrists, and

WHEREAS, When such payments are made, the hospitals are collecting monies for medical services that are provided by physicians and not by hospitals, and

WHEREAS, Private physicians, free of hospital control, can improve patient care by making constructive criticism of hospital programs, facilities and equipment, and

WHEREAS, Forcing these four physician specialties into the category of hospital employees may cause medical students to select a more independent type of practice, resulting in a shortage of physicians in these four specialties and a subsequent deterioration in the quality of patient care,

NOW, THEREFORE BE IT RESOLVED, That the West Virginia State Medical Association disapprove of the inclusion of the fees for professional services of radiologists, pathologists, anesthesiologists and physiatrists or any other doctor of medicine, as a part of the hospital service charge, and

BE IT FURTHER RESOLVED, That the Association assist these specialty groups to preserve their rights to practice their profession as individual and independent physicians and that the National Blue Cross Board of Directors and its president and the American Hospital Association and its officers be so advised.

* * * *

Subject: HR 6675

WHEREAS, There is under consideration in the Congress H. R. 6675, a bill which would provide certain limited health services for the aged, and

WHEREAS, there is included therein a provision for compulsory hospitalization financed by Social Security taxation, and

WHEREAS, There is a present attempt to include payment for in-hospital services rendered by pathologists, radiologists, anesthesiologists and physiatrists, which if enacted would be a definite step toward socialization of these specialties, and

WHEREAS, The principle of payment for services, where a need does or does not exist, by governmental agencies, is against the traditional principles of free enterprise in the practice of medicine, and

WHEREAS, This is an attempt to include services rather than cash benefits under Social Security taxation,

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association is ever mindful of its responsibility in providing a high quality of medical care without regard of fiscal responsibility of any patient, and is strongly opposed to any statute or regulation which would tend to socialize any branch of the medical profession, and

BE IT FURTHER RESOLVED, That our delegates to the American Medical Association, and our representatives in the Congress be advised of our stand in this matter.

Project Approved by Council

It was reported that the Cancer Committee of the State Medical Association had approved a proposed project on "Cancer of the Lung in Relation to Air Pollution" which would be sponsored by the Committee in cooperation with the State Department of Health.

It was explained that the project would be statewide and financed by a grant from the Environmental

Health Section of the U. S. Public Health Service under the direction of Dr. Thomas Mancuso of the University of Pittsburgh.

The Council went on record unanimously as approving the project.

Constitution and By-Laws

Dr. James S. Klumpp of Huntington, Chairman of the Committee on Constitution and By-Laws, reported that members of the Committee had undertaken a revision of the By-Laws during the past few months.

Doctor Klumpp said that another meeting of the Committee would be held in June and that a final report would be prepared for presentation to the Council and House of Delegates at the Annual Meeting in August.

Election of Honorary Members

The following physicians were elected to honorary life membership in the West Virginia State Medical Association:

Physician	*Address*	*Society*
Andrew E. Amick	Lewisburg	Greenbrier Valley
Marvin H. Porterfield	Martinsburg	Eastern Panhandle
C. J. Holley	Wheeling	Ohio
Milton S. Duling	Charleston	Kanawha
A. W. Milhoan	Nitro	Kanawha
O. C. Campbell	Hamlin	Cabell
O. L. Hamilton	Huntington	Cabell
George M. Lyon	Huntington	Cabell
Bruce H. Pollock	Huntington	Cabell
C. O. Reynolds	Huntington	Cabell
W. W. Strange	Huntington	Cabell

Miscellaneous

It was reported that Dr. C. A. Hoffman of Huntington would be a candidate for membership on the AMA Council on Medical Service and that the election would be held during the annual meeting in New York City in June. The Council went on record unanimously as endorsing the candidacy of Doctor Hoffman.

Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, presented a report on the activities of the Committee and stated that the annual report would be prepared in time for publication in the August issue of *The Journal*.

Mr. Harry Hinton of Chicago, AMA Field Representative, presented a detailed report on HR 6675—the Medicare bill. He also reviewed other legislation of interest to the medical profession now pending in Congress.

The Council meeting was attended by Dr. Charles L. Goodhand of Parkersburg, Chairman; Dr. Albert C. Esposito of Huntington, President; Dr. Seigle W. Parks of Charleston, President Elect; Dr. Richard E. Flood of Weirton, Vice President; Dr. L. J. Pace of Princeton, Councilor at Large; and Drs. G. Thomas Evans, Fairmont; Joseph L. Curry, Wheeling; Charles L. Leonard, Elkins; Maynard P. Pride, Morgantown; Andrew J. Weaver, Clarksburg; I. Ewen Taylor, Huntington; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; and D. Alene Blake, Oak Hill; and Mr. William H. Lively, Executive Secretary; and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington, AMA Delegates; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor of *The Journal*; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, Director of the State Department of Health; and Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; and Mr. Harry Hinton of Chicago, AMA Field Representative.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1965:

Barbour-Randolph-Tucker

Ormsbee, R. B. — Elkins

Boone

Vanstane, Virgil R. — Whitesville

Cabell

Auerbach, Sidney — Huntington
Burton, Zeb C., Jr. — "
Proctor, Herbert D. — "
Vanston, Gerald E. — "

Greenbrier Valley

McClure, Theodore R. — Marlinton
Smith, Barry M. — Green Bank

Harrison

Gasataya, Julian D. — Lumberport
Januszeski, Francis J. — Clarksburg

Kanawha

Josef, Ernesto J. — Ripley
Neville, Edwin C. — Charleston

Logan

Rudnick, Abraham H. — Man

McDowell

Ray, Joseph C. — Welch
Whitley, Ebb K., Jr. — Iaeger

Mercer

Barger, Carl C. — Bluefield
McRae, Henry G. — "
Powers, James E. — Princeton

Mingo

Davis, Everett G., Jr. — Williamson
Huffman, O. Lake — Gilbert
Varney, Frank T. — Stone, Ky.

Monongalia

English, Robert S. — Morgantown
Edwards, David E. — "
Watne, Alvin L. — "
Wolf, John H., Jr. — "

Ohio

McMurray, John T. — Wheeling
Naum, George P., Jr. — "

Raleigh

Nelson, Charles W., Jr. — Beckley
Warren, Harold D. — "
Warvariv, Eugene — "
Yates, Roy James — "

Wetzel

Blevins, Joseph W. — Hannibal, Ohio

Wyoming

Boonsue, Aarom — Mullens
Harlow, Gene W. — Pineville

New Association Members

Dr. Aarom Boonsue, 502 Moran Avenue, Mullens (Wyoming). Doctor Boonsue, who was born in Thailand, was graduated from Chulalongkok University and received his M. D. degree in 1951 from the University of Medical Sciences in Bangkok. He interned at Midstate Baptist Hospital in Nashville, Tennessee, 1960-61, and served a residency at Ohio Valley General Hospital in Wheeling, 1961-63. His specialty is anesthesiology.

* * * *

Dr. Alberto G. Capinpin, 1210 Virginia Street, East, Charleston (Kanawha). Doctor Capinpin, who was born in the Philippines, received his M. D. degree in 1953 from the University of Santo Tomas College of Medicine and Surgery in Manila. He interned at the University of Santo Tomas Hospital and Charleston General Hospital, 1952-55, and served a residency at Charleston General Hospital, 1955-59. He also had postgraduate work at the University of Texas Postgraduate School of Medicine. His specialty is plastic and reconstructive surgery.

* * * *

Dr. Herbert D. Proctor, 1115 Sixteenth Street, Huntington (Cabell). Doctor Proctor, a native of Landisburg, West Virginia, was graduated from Marshall University and received his M. D. degree in 1960 from the Emory University School of Medicine. He interned and served a residency at Grady Memorial Hospital in Atlanta, 1960-64. His specialty is internal medicine.

* * * *

Dr. Abraham H. Rudnick, Appalachian Regional Hospital, Man (Logan). Doctor Rudnick, a native of New York City, was graduated from New York University and received his M. D. degree in 1958 from Temple University School of Medicine. He interned at Maimonides Hospital in Brooklyn, 1958-59, and served a residency at Henry Ford Hospital in Detroit, 1959-62. His specialty is internal medicine and cardiology.

* * * *

Dr. Virgil R. Vanstane, Raleigh-Boone Medical Center, Whitesville (Boone). Doctor Vanstane, a native of Dawn, Missouri, was graduated from the University of Missouri and received his M. D. degree in 1926 from Rush Medical College of Chicago. He interned at St. Joseph's Hospital in Chicago. He served with the U. S. Army during World War I and he was previously located in Madison, Wisconsin. He is engaged in general practice.

* * * *

Dr. Gerald E. Vanston, St. Mary's Hospital, Huntington (Cabell). Doctor Vanston, a native of Scranton, Pennsylvania, was graduated from the University of Scranton and received his M. D. degree in 1959 from Jefferson Medical College of Philadelphia. He interned at Wilkes-Barre General Hospital, 1959-60, and served a residency at Jefferson Medical College Hospital, 1960-64. His specialty is pathology.

18,448 Children Are Eligible For Head Start Exams

Some 18,448 children throughout West Virginia will be offered health examinations during July and August as part of Project Head Start.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health," said that local health departments will coordinate the services and follow-up on children needing care.

Two mobile medical examination clinics from the State Department of Health will be available for use in the more remote areas. A nurse consultant and a public health educator have been assigned to work with local organizations to stimulate participation in the community and to coordinate activities.

Doctor Dyer noted that the multiphasic screening tests will be given by physicians, dentists, nurses and other health workers through existing community health resources and facilities. Examinations which are intended to provide an evaluation of the child's health will include: a physical examination by a physician; a history on medical, social and economic information about the family; a check for immunization status; screening tests for diabetes, phyenylketonuria, visual deficiencies, tuberculosis, speech and hearing defects and dental problems and tests for streptococcal infections.

Referrals will be made to practicing physicians of children needing care. When families are indigent, federal, state, local and voluntary sources that provide health services of many kinds will be enlisted to help

In another issue Doctor Dyer related that nearly 160,000 immunizations have been administered by local health departments throughout the state during the past year, a period coinciding with the concerted efforts of the Vaccination Assistance Project.

The vaccination program, now underway in 12 counties and in the developmental stage in another 15 counties, stresses the importance of immunization against smallpox, polio, diphtheria, tetanus and pertussis.

Doctor Dyer noted that the 160,000 immunizations reported against these diseases may be considered as an indication of the Vaccination Project campaign efforts. Although many physicians have indicated increased requests for immunizations and the campaign attempts to direct residents to their family physician, there is no way of determining the exact number of immunizations given until a re-survey is made at the end of the campaign.

He pointed out that the 1965 Immunization Activity Statistical Report from the Communicable Disease Center for Region III, West Virginia, shows that 70.7 per cent of the children in the under-5 age group in the state received the DPT series. These percentages are based on results of the sample surveys taken before the educational and promotional phase of the program was initiated. From April, 1964 to April,

1965, 23,520 doses of DPT vaccine were administered to the under-5 group through health department facilities.

Of the nearly 200,000 children in West Virginia under-5, only 37.7 per cent were considered protected against smallpox and during the past year only 8,307 doses were given to that group.

Polio protection levels in the same age group were slightly over 50 per cent. Local health departments reported 8,195 doses of Salk vaccine, 13,187 oral trivalent and 1,049 oral polio (Types 1, 2 and 3) given to children under-5.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28, 1965.

A cordial invitation to attend all sessions has been extended by the Program Committee to interns and physicians serving in hospitals in West Virginia and adjacent states.

Requests for hotel accommodations should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

Regional GP Meeting Held In Sutton on June 13

Four members of the faculty at the West Virginia University School of Medicine presented papers at a regional meeting of the West Virginia Chapter of the American Academy of General Practice which was held at the National Guard Armory near Sutton on Sunday, June 13.

The speakers were Dr. Byron M. Bloor, Professor and Chairman of the Division of Neurosurgery; Dr. Stancil E. D. Johnson, Instructor in Psychiatry; Dr. Robert R. Trotter, Clinical Associate Professor of Surgery and Chairman of the Division of Ophthalmology; and Dr. Robert J. Herm, Assistant Professor of Ophthalmology.

Drs. L. Dale Simmons of Clarksburg and W. W. Huffman of Gassaway were in charge of arrangements for the one-day meeting, which was presented in cooperation with Eli Lilly and Company.

Congress on Medical Ethics

The American Medical Association will sponsor a National Congress on Medical Ethics and Professionalism at the Drake Hotel in Chicago on October 2-3, 1965.

Physicians interested in attending the Congress should write to Dr. James H. Berge, Chairman of the Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, for detailed information.

Reservations will be accepted by the Drake on a first-come-first-serve basis.

State Mental Health Department Hires Medical Supervisor

Dr. Norman A. Desrosiers has been named Supervisor of Medical Services for the West Virginia Department of Mental Health.

Doctor Desrosiers joined the Department on June 1 after serving as Medical Director of the North Carolina Alcoholic Rehabilitation Program.

A native of Providence, Rhode Island, Doctor Desrosiers holds bachelor's degrees from Duke University, including a degree in divinity. He turned to medicine in 1955 and received his M. D. degree from the University of North Carolina.

Technologists Elect Officers

Mrs. Lillian Page of Martinsburg was installed as President of the West Virginia Society of Medical Technologists during a meeting in Huntington, May 21-22.

Dane Moore of Morgantown was chosen President Elect. Other officers for the coming year are Miss Jane Chatfield of Charleston, Secretary, and Miss Ester Levine of Fairmont, Treasurer.

Dr. Yurko Joins National Steel

Dr. Anthony A. Yurko of Weirton has been appointed Director of Medical and Health Services for National Steel Corporation.

Doctor Yurko will leave private practice in the next few months to devote full time to the new position. He will have offices in Weirton.

A native of McKeesport, Pennsylvania, Doctor Yurko has practiced in Weirton since 1934. He received his M.D. degree from the Medical College of Virginia in 1933.

Dr. Raul Vela Receives Award

Dr. Raul Vela, a resident in surgery at Charleston General Hospital, was one of the winners of a cash prize for the best paper presented by resident physicians during the recent meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs.

The subject of Doctor Vela's paper was "Vagotomy and Pyloroplasty for Duodenal Ulcer."

College Honors Two Physicians

Two physicians—Drs. Robert L. Chamberlain of Buckhannon and Paul L. McCuskey of Parkersburg—have been cited as West Virginia Wesleyan College's "Alumni of the Year."

The two physicians received plaques at a recent alumni banquet in Buckhannon, which was attended by approximately 300 persons.

Doctor Chamberlain did not remain for the entire meeting. He was called out on an emergency.

Dr. Benjamin W. Drompp To Speak Before Orthopedic Section

Dr. Benjamin W. Drompp of Little Rock, Arkansas, will be the guest speaker before a meeting of the Section on Orthopedic Surgery which will be held at The Greenbrier in White Sulphur Springs on Friday afternoon, August 27.

Benjamin W. Drompp, M. D.

The meeting will be held in conjunction with the 98th Annual Meeting of the West Virginia State Medical Association.

Doctor Drompp, who is Professor and Head of the Division on Orthopedic Surgery at the University of Arkansas Medical Center, will present a paper on "Current Concepts in the Surgery of Rheumatoid Arthritis."

A native of Logansport, Indiana, Doctor Drompp was graduated from Wayne State University and received his M.D. degree in 1953 from Wayne State University College of Medicine. He served his internship and had residency training at several hospitals in Detroit.

He joined the faculty of Wayne State University College of Medicine in 1958 and was serving as Associate Professor of Orthopedic Surgery when he accepted his present appointment at the University of Arkansas Medical Center in 1962. He also serves as Chief Consultant in Orthopedic Surgery at the VA Hospital in Little Rock.

He was certified by the American Board of Orthopedic Surgery in 1960 and is the author of numerous papers which have appeared in professional journals.

Dr. N. H. Dyer Receives Honorary Degree

State Health Director N. H. Dyer was awarded an honorary Doctor of Public Health degree during commencement exercises at West Virginia Wesleyan College in Buckhannon on May 30.

A native of Bolair in Webster County, Doctor Dyer attended West Virginia Wesleyan before receiving his medical education at the University of Maryland.

Doctor Dyer served as medical director and plant physician for the Pond Creek Pocahontas Company for 20 years before he was appointed State Health Commissioner in 1946. Three years later he became Director of the State Department of Health, a post he has held since that time.

Doctor Dyer was also honored several years ago when he was awarded an honorary Doctor of Public Administration degree by Marshall University.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next 12 months:

1965

July 16-17—Rocky Mtn. Cancer Conf., Denver.
Aug. 26-28—W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.
Aug. 30-Sept. 2—American Hosp. Assn., San Francisco.
Sept. 9-11—American Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 10—Maryland Medical Society, Ocean City.
Sept. 21-23—Kentucky Medical Assn., Louisville.
Sept. 18-26—Pennsylvania Medical Soc., Atlantic City.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 1-2—W. Va. Chapter, ACS, Morgantown.
Oct. 7-9—ACP, Miami Beach.
Oct. 10-13—Medical Soc. of Virginia, Richmond.
Oct. 15-19—American Heart Assn., Bal Harbour, Fla.
Oct. 18-22—ACS Clinical Cong., Atlantic City.
Oct. 23-28—American Acad. of Ped., Chicago.
Oct. 27-29—American Cancer Soc., New York.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical Assn., Houston.
Nov. 14-19—American Acad. of Oph. & Otol., Chicago.
Nov. 27-28—ACCP, Philadelphia.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 26-30—AMA Annual Meeting, Chicago.

Doctor Farnsworth Honored

Dr. Dana L. Farnsworth, a native of Roane County, received an honorary Doctor of Science Degree from West Virginia University during Commencement Exercises which were held in Morgantown on May 31.

Doctor Farnsworth is director of the Harvard University Health Services and is Professor of Hygiene. He attended Glenville State College and received degrees from WVU and the Harvard Medical School.

Medical Assistants Elect Officers

Mrs. Betty Archer of Huntington was named President Elect of the West Virginia Medical Assistants Society during the recent annual convention in Beckley. She succeeds Mrs. Lyda Plymale.

Other officers in addition to Mrs. Archer are: Mrs. Juanita Rauch of Parkersburg; President; Mrs. Dora De Hart of Beckley, Vice President; Mrs. Leona Grow of Parkersburg, Treasurer; and Mrs. Arie Nahodil of Charleston, Recording Secretary.

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WVU Medical Center
–News–

DR. Michael F. Wilson, an alumnus of West Virginia University, has been named Chairman of the Department of Physiology at the WVU School of Medicine.

Doctor Wilson assumed the post on June 1, succeeding Dr. David W. Northup, who will remain as Professor of Physiology. Doctor Wilson most recently served as Associate Professor of Physiology and Biophysics in the College of Medicine at the University of Kentucky.

Doctor Wilson was graduated from West Virginia University in 1949 and received his M.D. degree in 1953 from the University of Pennsylvania School of Medicine. After serving his intern and residency and fellowship training, he joined the staff at Kentucky in 1960.

Doctor Chamberlain Receives Award

Dr. C. Richard Chamberlain, Jr., Assistant Professor of Pathology at the West Virginia University School of Medicine, has been presented the MacLachlan Memorial Award for 1965.

The award is presented annually to "the basic science teacher who, in the opinion of the second year class, demonstrated unusual teaching ability and a sincere interest in the progress of the entire class."

Doctor Chamberlain received the award at the annual School of Medicine Awards Convocation on May 20. Arrangements for the award were made by an anonymous donor as a memorial to the late Dr. P. L. MacLachlan, former Chairman of the Department of Biochemistry at the School of Medicine.

Books Contributed to Library

Two nationally known ophthalmologists have contributed books and journals valued at $5,060 to the Division of Ophthalmology at the West Virginia University School of Medicine.

Dr. Robert R. Trotter, Chairman of the Division of Ophthalmology, said the donors were Dr. Francis Heed Adler, professor emeritus of ophthalmology at the University of Pennsylvania, and Dr. S. Rodman Irvine of Beverly Hills, California. Doctor Irvine is clinical professor of ophthalmology at the University of California in Los Angeles.

The recent contributions included the bulk, if not the entire collection from the private library of Doctor Adler. The collection contained 197 books on ophthalmology, 252 bound volumes of journals and 277 unbound journals.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Doctor Irvine's gift consisted of 77 books, 63 volumes of bound journals and 62 unbound journals.

Technology Program Established

A two-year program for x-ray technologists will be started this fall at West Virginia University Hospital.

Eugene L. Staples, Hospital Director, said a maximum of 10 students will be admitted to each class starting September 1. The program will be under the direction of Dr. Harold I. Amory, Chairman of the Department of Radiology.

To be eligible for admission to the program, a person must be between the ages of 18 and 35, be a high school graduate and must pass an aptitude test given by the State Employment Office. Tuition is $100 for the two-year course.

William Neal of Huntington, a junior student at the West Virginia University School of Medicine, has been given the first Edward J. Van Liere award. The engraved medal and $100 in cash were presented to Neal for preparing the best paper on a research project at a recent convocation at the Medical Center. The award is named in honor of Dr. Edward J. Van Liere, who has been associated with the School since 1921 as Dean and now Professor of Physiology.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association warned Congress that passage of the medicare bill could lead eventually to the troubles encountered in nations that have centralized government medical plans.

"The American system of medicine for generations has been a system of quality medicine, practiced through a voluntary relationship between patients and physicians, with doctors free to make decisions based on the patient's specific needs and nothing else," Dr. Donovan F. Ward, AMA President, told the Senate Finance Committee.

"Yet we have seen the trying problems in other lands and the results engendered by centralized government programs to provide health care for a large segment of the population," Doctor Ward declared. "Long waits, poor equipment and facilities, short, impersonal examinations, and lots of record keeping appear to be the major accomplishments of nationalized health systems. Can we hope the American plan will be so different as to negate all these adverse factors?

"We think not. Forget for a moment the staggering, though unpredictable, cost of the pending program. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale.

"Look only at the intrusion of government in the field of medicine, which cannot be avoided if this measure is adopted. With the quantity of care thus restricted for the sake of controlling costs, the quality must deteriorate. The patient is the ultimate sufferer. But this disillusionment is shared by those who serve him. With the advent of state medicine, professional discontent appears to be the rule rather than the exception. Look again at the experience of the foreign programs.

"This may be our last chance to ask you to write legislation which will meet the nation's needs and at the same time avoid the pitfalls of a government-financed, government-controlled, and government-oriented health care system. This may be your last chance to weigh the consequences of taking the first step toward establishment of socialized medicine in the United States," Doctor Ward concluded.

Vaccination Against Smallpox

Continuing emphasis on vaccination against smallpox in the United States was urged by the AMA. Following announcement that a case of the disease had been discovered in Washington, D. C., the AMA declared that there was no basis for panic or alarm, and said that there was no need for emergency, mass vaccination campaigns.

The AMA said the effectiveness of endeavors of the American Medical Association, local medical societies, physicians, hospital administrations, and government health agencies to raise the level of immunity to smallpox through vaccination were challenged with the first case of smallpox reported in the country in 20 years.

"Because of the hazard of such importations of smallpox, a disease which can kill or maim, the AMA and others have advocated continuing vaccination programs in this country," the AMA said. "The danger was particularly emphasized over two years ago by Dr. Raymond L. White, director of the Division of Socio-Economic Activities of the AMA. Doctor White pointed out the need for 'defense in depth' through ongoing intensive vaccination programs for those who are apt to contact international travelers, and those who meet or treat the sick, in addition to the general public programs."

Connecticut's Contraceptive Law

The Supreme Court held that Connecticut's 1879 law forbidding use and prescription of contraceptives is unconstitutional.

The majority in the 7-2 opinion said that "a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedom."

The challenge to the Connecticut law was made by the State's Planned Parenthood League. It stemmed from the conviction of Mrs. Estelle T. Griswold and Lee Buxton, M. D., on charges of violating the law by operating a birth control clinic.

An attempt to challenge the law was made in 1961, but the Supreme Court refused to consider the issue then because no arrests had been made.

"Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives?" the opinion said. "The very idea is repulsive to the notions of privacy surrounding the marriage relationship."

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Obituaries

HOWARD TROY PHILLIPS, JR., M. D.

Dr. Howard Troy Phillips, Jr., of Wheeling, died suddenly in a hospital in that city on May 16. He was 44.

He was born in Cleveland on July 16, 1920, the son of the late Dr. Howard T. Phillips and Jessie Beavers Phillips.

Doctor Phillips was graduated from West Virginia University and received his M.D. degree in 1945 from Jefferson Medical College in Philadelphia. He was a Diplomate of the American Board of Dermatology and was a member of the Ohio County Medical Society, West Virginia State Medical Association and the American Medical Association.

During World War II, he served as a Lieutenant (j.g.) in the U. S. Navy and was later active in the Naval Reserve.

Survivors include the widow, the former Virginia Lee Fleming of Fairmont; four sons, Howard Troy III, John Fleming, Michael Beavers, and Mark Cornwell, all at home; and two brothers, Dr. William A. Phillips of Wilmington, North Carolina; and Dr. Robert L. Phillips of Greensboro, North Carolina.

NORMAN RANDOLPH PRICE, M. D.

Dr. Norman R. Price of Marlinton, who practiced medicine in Pocahontas, Randolph, Webster and Nicholas counties since 1903, died in May. He was 89.

A native of Mount Clinton, Virginia, Doctor Price received his M.D. degree from Maryland Medical College. He was a former member of the West Virginia State Medical Association and once served as President of the Greenbrier Valley Medical Society.

Doctor Price served as a member of the Pocahontas County Court from 1910 to 1918 and was Mayor of Marlinton, 1923-27.

* * * *

CHARLES T. ST. CLAIR, JR., M. D.

Dr. Charles T. St. Clair, Jr., an eye, ear, nose and throat specialist in Bluefield for many years, died in a Bluefield Hospital on June 7 after an illness of several months. He was 66.

A native of Tazewell, Virginia, Doctor St. Clair settled in Bluefield at an early age. He attended Virginia Military Institute and the University of Virginia and received his M. D. degree in 1932 from the Medical College of Virginia.

Doctor St. Clair and his father were associated together in medical practice until the elder physician's death a few years ago. He was a past President of the West Virginia Academy of Ophthalmology and Otolaryngology and held membership in the Mercer County Medical Society, the West Virginia State Medical Association and the American Medical Association.

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M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
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Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
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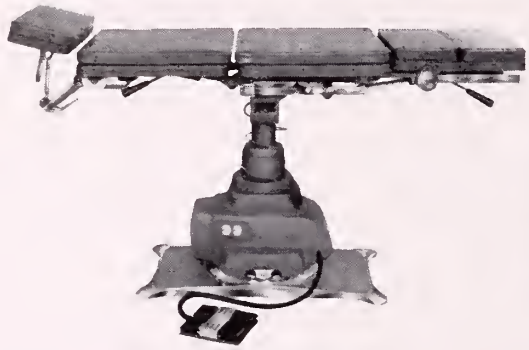

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OBITUARIES—(Continued)

Doctor St. Clair was married to the former Miss Natalie Maynard of Bluefield, who died in 1962.

Survivors include two children, Charles T. St. Clair III of Columbus, Ohio, and Mrs. Norvell Sutherland of West Palm Beach, Florida; and five grandchildren.

* * * *

JOHN PAUL TRACH, M. D.

Dr. John Paul Trach, 63, of Fairmont, died on May 15 while playing golf at the Fairmont Field Club.

A practicing physician in Fairmont for 32 years, Doctor Trach attended Gettysburg College and the West Virginia University School of Medicine for two years. He received his M.D. degree in 1931 from the University of Louisville School of Medicine.

Doctor Trach interned at St. Francis Hospital in Pittsburgh before establishing his practice in Fairmont in 1933.

Doctor Trach held membership in the Marion County Medical Society, West Virginia State Medical Association, the American Medical Association and the American Academy of General Practice.

In addition to the widow, survivors include six children, Mrs. Edwin Thomas Stitt of Mt. Lebanon, Pennsylvania; Mrs. Charles Sands Welton of Lakeland, Florida; John Paul Trach II, Marthell Morgan Trach, Elizabeth Trach and James Mark Trach, all of Fairmont.

$771 Million in Surgical Expense Benefits Paid in 1964

Surgical benefits paid out in 1964 by insurance companies totaled over $771 million, the Health Insurance Institute reported recently. That figure, the Institute said, is 11 per cent above 1963's $695 million and represents a record high for this insurance.

These insurance company benefit payments were paid under surgical expense coverages, and under surgical provisions of major medical expense policies. The Institute noted that total health insurance benefits by insurance companies last year amounted to nearly $4.7 billion. In addition to surgical coverage, benefits were provided under hospital, regular medical, major medical, and disability income insurance programs.

Surgical benefits under a basic hospital-surgical policy are paid according to a listed scale of procedures. Schedule maximums range from $250 to $600, depending on the policy. Under major medical expense policies, the benefits are determined by the customary and usual fees charged for specific operations.

At the end of 1963, nearly 85 million persons had surgical expense protection through insurance company group or individual and family policies, the Institute said.

Insuring organizations such as Blue Cross and Blue Shield protected another 52.5 million, and 8.6 million persons were covered by other health care programs. The net total protected for surgical expenses in 1963: 134.9 million persons.

The estimated surgical coverage figure for 1964 is 139 million persons, the Institute said.

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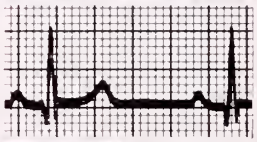

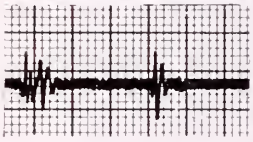

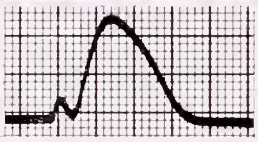

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County Societies

B-R-T

The regular monthly meeting of the Barbour-Randolph-Tucker Medical Society was held at Hienbaugh's Restaurant in Parsons on May 20.

The program was presented by Drs. John Harley and Wayne Spiggle of the West Virginia University School of Medicine. They discussed "Recent Advances in Treatment of Multiple Myeloma." A question and answer period followed.

Dr. Homer D. Martin of Dailey was installed as President of the Society for the coming year.

Other new officers are: Drs. Evangeline M. Poling of Philippi, First Vice President; Semon M. Lilienfeld of Parsons, Second Vice President; A. Kyle Bush of Philippi, Secretary; and Guy H. Michael, Jr., of Parsons, Treasurer.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Dr. Henry J. L. Marriott of Tampa, Florida, was guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on May 13.

Doctor Marriott, who is Director of Medical Education at Tampa General Hospital, discussed "Medical Education and the Community Hospital." He expressed the belief that the community hospital is a natural workshop for the continuing education of physicians of all ages.

The Society approved an Executive Committee recommendation that it award three one-year premedical scholarships totaling $3,750 to Marshall University. It was suggested that the recipients should be West Virginia students and that the Society should retain some control over the scholarships.

The applications for honorary membership of Drs. O. L. Hamilton and O. C. Campbell were approved unanimously.—Harold N. Kagan, M. D., Secretary.

* * * *

FAYETTE

Dr. Sherl J. Winter of Beckley was guest speaker at the regular monthly meeting of the Fayette County Medical Society which was held at the White Oak Country Club in Oak Hill on May 5.

Doctor Winter presented an interesting paper on "Pediatrics in General Practice." He emphasized electrolyte determination and how to correct it in children. He also discussed measles and immunization.

Seven members attended the meeting.—W. P. Bittinger, M. D., Secretary.

* * * *

KANAWHA

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, was guest

speaker at the regular monthly meeting of the Kanawha Medical Society which was held at the Daniel Boone Hotel in Charleston on June 8.

Doctor Esposito reviewed the status of pending medicare legislation and appealed for a strong political action program on the part of organized medicine in West Virginia.

Dr. Edward Jackson of St. Albans, President of the Society, presided at a business session during which a number of resolutions were discussed.

* * * *

MARION

Dr. Robert J. Sidow of Fairmont was elected President of the Marion County Medical Society during the regular monthly meeting which was held in Fairmont on May 25.

Doctor Sidow succeeds Dr. William T. Lawson of Fairmont.

Other officers elected at the meeting are: Dr. Jack C. Morgan of Fairmont, Vice President; Dr. G. T. Evans of Fairmont, Secretary; Dr. Robert R. Frye of Mannington, Treasurer; and Drs. David Bressler, John J. Coogle, Robert G. Janes and Lawson, all of Fairmont, members of the Board of Directors.

The Society elected Drs. John W. Kramer and Robert S. Mutch as new members.

* * * *

MERCER

Dr. C. C. Coleman, Jr., of Richmond, Virginia, was guest speaker at the regular monthly meeting of the Mercer County Medical Society, which was held at the West Virginian Hotel in Bluefield on May 17.

Doctor Coleman presented an interesting paper on "Reconstructive Surgery of Infancy and Childhood." The talk was illustrated by color slides.

Dr. L. J. Pace of Princeton, a member of the Council of the West Virginia State Medical Association, gave a report on the Council meeting held on May 16. Dr. Frank J. Holroyd of Princeton gave a report on the Medicare Bill.—John J. Mahood, M. D., Secretary.

* * * *

MONONGALIA

Dr. Margaret A. Wilson, Director of the Dietary Service at the WVU Hospital, was the guest speaker

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at the regular monthly meeting of the Monongalia County Medical Society which was held at the Hotel Morgan on May 4.

Doctor Wilson gave an interesting talk on the dietary management of the diabetic.

Dr. Fred Miltenberger, a surgical resident at West Virginia University Hospital, was the guest speaker at the monthly meeting of the Monongalia County Medical Society on June 1.

Doctor Miltenberger presented an interesting paper on anti-diuretic hormones.

The Society elected Drs. David E. Edwards and John Fullmer to full membership and Dr. Antonio Palladino to affiliated membership.—George A. Curry, M. D., President.

* * * *

RALEIGH

Dr. Ernest W. Chick, Professor of Preventive Medicine at West Virginia University, was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at the Beckley Hotel on May 19.

The Raleigh County Tuberculosis and Health Association met jointly with the Medical Society. More than 125 persons attended the dinner.

Doctor Chick explained the techniques of preventive medicine used in the fight against tuberculosis.

Woman's Auxiliary

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Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William R. Rice, Dunbar.

RALEIGH

Mrs. Warren D. Elliott was installed as President of the Woman's Auxiliary to the Raleigh County Medical Society at a luncheon meeting held at the Beckley Hotel on May 17.

Mrs. Elliott succeeds Mrs. Charles W. Merritt.

The President Elect is Mrs. Everett B. Wray, Jr. Other new officers are Mrs. Lewis N. Fox, Vice President; Mrs. Ira Braxton Anderson, Corresponding Secretary; Mrs. William D. McLean, Recording Secretary; and Mrs. John M. Daniel, Treasurer.

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Barbour-Randolph-Tucker	Ernest G. Guy	Philippi	A. Kyle Bush	Philippi	3rd Thurs.
Boone	Harald H. Howell	Madison	David E. Wallace	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	W. R. Wilkinson	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	I. F. Hartman	Buckhannon	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	C. V. Tawnsend	Martinsburg	2nd Wed.
Fayette	D. Alene Blake	Oak Hill	W. P. Bittinger	Oak Hill	1st Wed.
Greenbrier Valley	Robert G. Shirey	Lewisburg	Claude L. Houck	Lewisburg	2nd Wed.
Hancock	J. L. Thompson	Weirton	George S. Kasar	Weirton	2nd Tues.
Harrison	A. Robert Marks	Clarksburg	James A. Thompson	Clarksburg	1st Thurs.
Kanawha	Edward Jackson	St. Albans	Jerill D. Cavender	Charleston	2nd Tues.
Logan	Lyle H. Bayea	Man	Kwan Ho Lee	Logan	2nd Wed.
Marion	W. T. Lawson	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	3rd Tues.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	J. Hunter Smith	Welch	David J. Skewes	Welch	2nd Wed.
Mercer	Sam Milchin	Bluefield, Va.	John J. Mahaod	Bluefield	3rd Mon.
Mingo	Enoch W. White, Jr.	Red Jacket	L. Lake Swigart	Williamson	2nd Wed.
Monongalia	George A. Curry	Margantown	Wm. E. King	Morgantown	1st Tues.
Ohio	Warren D. Leslie	Wheeling	A. M. Valentine	Wheeling	4th Tues.
Parkersburg Academy	E. B. Holmes	Parkersburg	Delmer J. Brown	Parkersburg	1st Thurs.
Potomac Valley	Beverly N. Chambers	Maorefield	Robert W. Bess, Jr.	Piedmont	2nd Wed.
Preston	Jahn W. Trentan	Kingwood	C. W. Moser	Kingwood	4th Thurs.
Raleigh	Warren D. Elliott	Beckley	W. W. McKinney	Beckley	3rd Thurs.
Summers	Buford W. McNeer	Hinton	Jack D. Woodrum	Hinton	3rd Mon.
Taylor	Paul P. Warden	Grafton	Herbert N. Shanes	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watsan	N. Martinsville	Monthly
Wyoming	Frank J. Zsaldas	Mullens	Ross E. Newman	Mullens	Quarterly

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Book Reviews

TRAUMA TO THE LIVER—By Gordon F. Madding, M. D., M. S. (Surgery), F.A.C.S., Associate in Surgery, Stanford University Medical School; Paul A. Kennedy, M. D., F.A.C.S., Clinical Instructor in Surgery, Stanford University Medical School. W. B. Saunders Company, Philadelphia and London. 1964. Pp. 134. Illustrated. Price: $6.00.

The third book in the series "Major Problems in Clinical Surgery" is just as interesting and helpful as those published in 1964.

This monograph deals with those problems encountered in every variety of trauma to the liver and their sequelae. We all wonder in times of liver emergency just what to do, since so many of these techniques for repair and diagnosis are not described at all in even the modern texts and journals. The authors have meticulously attempted to correlate their personal experience as well as that of others, in order that more of these patients may be salvaged.

An excellent book for the surgeon's library and a guide in instructing the house staff.—Kenneth G. MacDonald, Sr., M. D.

In the past 20 years life expectancy has been increased by almost 20 per cent. Better drugs, along with better nutrition, improved medical care and public health and sanitation measures, have increased average life expectancy from 59.7 years in 1930 to 62.9 years in 1940 to almost 70 years today.

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The West Virginia Medical Journal

August, 1965 Vol. 61, No. 8

Selective Renal Arteriography: Community Hospital Potential

Joseph L. Curry, M. D., and Willard J. Howland, M. D.

The first selective renal arteriogram was performed on a postmortem specimen in 1896, one year after the discovery of x-ray, and indicates surprisingly good detail (Figure 1).

Roentgen evaluation of the kidney during life by the opacification of its vasculature became a reality with the advent, in 1929, of direct needle puncture aortography by dos Santos.[1] The production, however, of aortograms of consistently high diagnostic quality with relative safety had to await the development of improved mechanical and electronic apparatus, as well as the discovery of contrast media of low toxicity.

The ingenious percutaneous arterial catheterization technique of Seldinger, of Sweden, first published in 1953, now permits a simple, precise and relatively safe method of performing combined aortography and selective renal arteriography. This involves the passing of a smooth plastic catheter over a thin intravascular wire.[2] Selective renal arteriography has become popularized in recent years by the inspiring publications and exhibits of such talented observers as Evans, Sutton, Amplatz and Olsson, to mention a few.[3, 4, 5, 6]

During the past two years, we have performed 817 arteriograms in a community hospital. Of these, 152 have been renal arteriograms, the majority being selective catheter studies (Table 1). The relative simplicity and safety of this technique, which affords extremely precise diagnostic information, would seem to justify a more rapid replacement of translumbar percutaneous needle aortography. Because this method provides valuable information often unavailable by other means, there are many instances in which its proper use would avoid unnecessary surgical

The Authors

- **Joseph L. Curry, M. D., and Willard J. Howland, M. D., Department of Radiology, Ohio Valley General Hospital, Wheeling, West Virginia.**

Figure 1

Figure 1. Renal arteriogram produced by opaque injection of arteries of a postmortem renal specimen in 1896 (From Sutton, D., "Arteriography," 1962—Reproduced by permission of E. & S. Livingstone, Ltd., Edinburgh and London).

exploration (Figures 2 and 3). Conversely, this technique can detect the presence of occult renal disease such as neoplasm (Figure 4). Indeed, there are situations in which information provided by selective renal arteriography is much more precise than that afforded by direct surgical inspection of the kidney (Figure 5). By this method, congenital hypoplasia of the kidney also may be differentiated from acquired pyelonephritic atrophy (Figure 6).

In addition to the evaluation of renal parenchymal disease, renal arteriography is also unrivaled in the diagnosis of many renal vascular lesions. These include stenosis, aneurysm and acute renal trauma (Figures 7 and 8). The latter will be the subject of a subsequent communication.

Table 1

Renal Angiography—January 1963 to December 1964
Ohio Valley General Hospital, Wheeling, West Virginia

Selective Renal	
(Plus Aortography)	
Femoral catheter	83
Axillary catheter	21
*Aortography for Renal Evaluation**	
(Without selective renal arteriography)	
Femoral catheter	30
Axillary catheter	6
Retrograde axillary cannula	2
Retrograde femoral cannula	7
Translumbar percutaneous needle	3
	152

*Of these, 31 were evaluated for possible renovascular hypertension.

A reasonably complete angiographic evaluation of the kidney usually involves three basic components:

1. Catheter aortography.
2. Selective renal arteriography.
3. Rapid serial films procured throughout all phases of the circulation.

Catheter aortography is far superior to needle aortography since the catheter position may be easily varied under direct fluoroscopic guidance and a larger bolus delivered in a shorter time. (In adults, a pressure injector is necessary for rapid delivery of the opaque bolus into the aortic stream). The same catheter then can be guided into one or both renal arteries for selective studies, using a hand syringe injection. A palpable femoral or axillary artery is punctured instead of making a "blind" aortic puncture where bleeding may be unsuspected and cannot be readily controlled.

Preliminary aortography is generally desirable in order to recognize and localize the size and

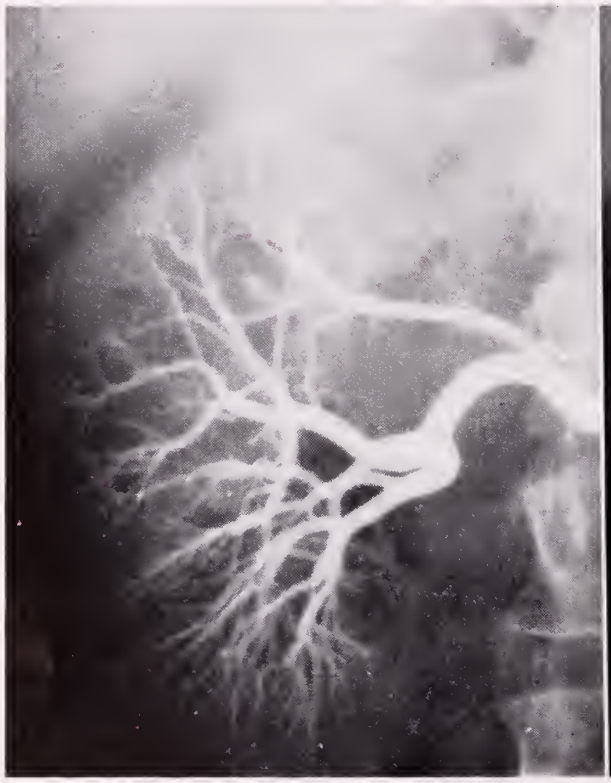

Figure 2-A

Figure 2-B

Figure 2. Selective renal arteriogram of a 53-year-old male in whose case a renal mass was palpated during emergency surgery for duodenal ulcer. Subsequent urography was negative, and there were no urinary tract signs nor symptoms. (A). Arterial phase film which appears normal. (B). Vascular nephrogram three seconds later showing parenchymal cortical impressions by cysts.

number of renal arteries present. Multiple renal arteries exist in approximately 24 per cent of persons.[7] These radiographs also allow the examiner to avoid catheter trauma to small or diseased renal arteries.

In selected cases, the renal artery may be directly catheterized as a primary procedure if the examiner wishes to avoid a "urogram contamination" of the field by preliminary aortography.

In selective renal arteriography a catheter of the shape shown in Figures 2 and 3 will enter the renal artery of most patients. Thus, the renal circulation is selectively visualized and isolated from other abdominal vessels. Side holes placed near the catheter tip allow the same catheter to be used for the preliminary aortogram.

Rapid serial films are essential in selective renal arteriography since many lesions are shown with certainty in only one phase of the circulation (Figure 2). This appears to be just as important in renal arteriography as it is in cerebral arteriography.

Indications

Renal arteriography may be employed whenever precise information is necessary in diseases of the renal vasculature or parenchyma. It is of questionable value in lesions confined to the pelvocaliceal system.[8] Selective renal arteriography provides precise information which is usually far superior to aortography alone. Although extremely valuable in many other situations, selective renal arteriography is of paramount importance in the differentiation of small neoplasms and between cyst and neoplasm.[4, 9, 10]

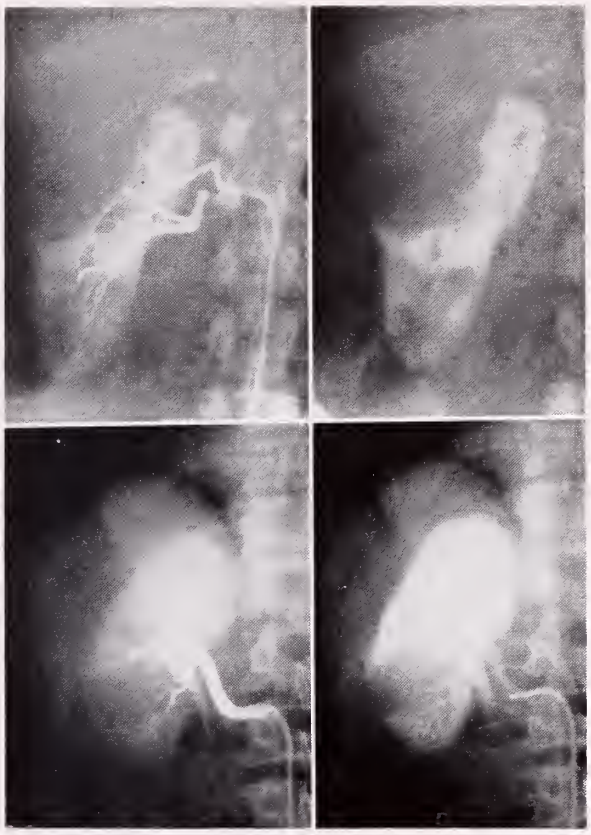

Figure 3

Figure 3. Examples of cortical (top) and intrarenal (lower) cysts.

Table 2 indicates renal abnormalities which were demonstrated in this series.

Table 2

Abnormalities Encountered in 152 Renal Angiograms

Renoparenchymal	
A. Cyst:	
Cortical	9
Intrarenal	6
B. Congenital polycystic disease	1
C. Neoplasm	11
D. Agenesis	1
E. Congenital hypoplasia	3
F. Chronic pyelonephritis	7
G. Tuberculosis	1
H. Hydronephrosis (Pyelography unsatisfactory)	3
I. Medullary sponge kidney	1
	43
Renovascular	
A. Renal artery stenosis	
Atherosclerosis	6
Fibrous & fibromuscular	3
B. Renal artery aneurysm	2
C. Calcification of intrarenal arteries	1
D. Acute renal trauma	1
	13

Complications

No renal complications have been recognized in this series. Of 503 catheter arteriograms, the femoral artery has been punctured in 460, the axillary in 43.

Prolonged severe femoral artery bleeding occurred in only one case, the patient being examined while under intensive anticoagulant therapy. No difficulties were encountered in noncatheter, direct-cannula arteriographic studies in seven other cases in which the patients were known to be under anticoagulant treatment. Thromboses and prolonged arteriospasm were encountered (Table 3) but did not require surgical intervention, and no "follow-up" arteriography of the involved arteries was performed. Other complications were encountered in carotid catheter studies but were usually of transient nature and are unrelated to this study.[11]

Lang's[12] survey of complications in over 11,000 catheter arteriograms is noteworthy and indicates a relatively low complication rate with 0.06 per

C D

Figure 4

Figure 4. Occult Carcinomas: (Top) Surgically verified renal carcinoma found in a 43-year-old male examined for suspected renovascular hypertension. Urogram was normal. (Lower) Fifty-three-year-old male. (C). Mass in upper pole of right kidney shown in pyelogram. (D). Arteriogram shows urographically occult parahilar carcinoma in conjunction with a benign upper pole cyst, surgically verified.

cent mortality while Adeney and Fraser[13] report no complications in 103 cases of catheter renal arteriography.

Discussion

With a modest experience and scrupulous observations of well-established techniques, combined catheter aortography and selective renal arteriography is relatively safe and efficient and should enjoy ever-increasing use. The abdominal aorta usually can be catheterized by the femoral artery which affords a short and convenient route to the kidneys. When arterial disease renders transfemoral catheterization of the aorta hazardous or impossible, the left axillary approach may be employed.[14] In cases in which the femoral or axillary approach cannot be used, retrograde pressure arteriorgraphy by the left brachial, left axillary or either femoral artery often produces films comparable to translumbar percutaneous needle aortography.[15, 16]

This experience suggests that anything less than combined aortography and selective renal arteriography with multiphase circulation films usually represents an incomplete renal angiogram for parenchymal disease. The examiner cannot expect a diagnostic procedure of potential and consistently high accuracy if important parts of the examination are excluded. Literature reports which question the diagnostic accuracy of arteriography in renoparenchymal disease[17] should be accepted with reservation if serial film, selective arteriography has not been employed.

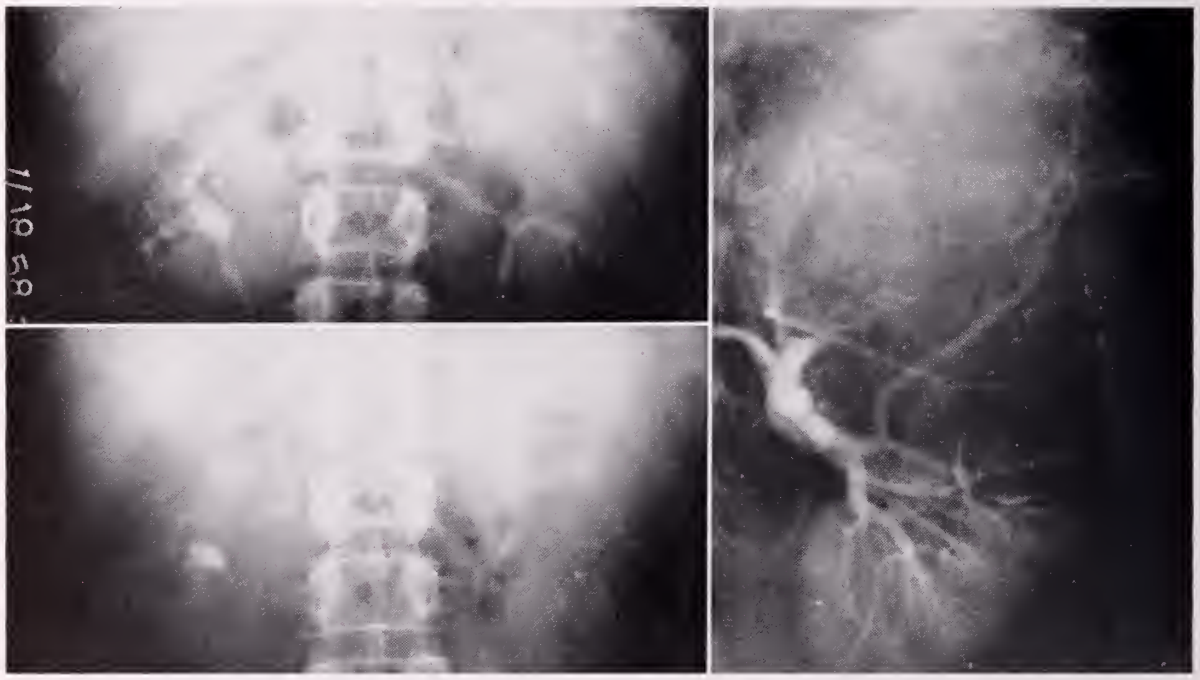

Figure 5-A and B Figure 5-C

Figure 5. (A and B). Mass lesion in upper pole of left kidney of a 50-year-old male showing no change in size by urography over a five-year period. Selective arteriography of this patient consistent with a cystic carcinoma (C). Urologic surgeon suspected benign multicystic renal mass at nephrectomy but microscopic study confirmed the diagnosis of a cystic carcinoma.

Before engaging in these techniques, the prospective arteriographer is well advised to directly observe clinical procedures at one of the many medical teaching centers or large community hospitals where these examinations are performed frequently.

Summary and Conclusions

1. In renovascular and renoparenchymal disease, selective renal angiography provides consistently precise information, often unavailable by any other method.

2. Preliminary aortography and serial films throughout all phases of the renal circulation are necessary for optimal evaluation.

3. Preliminary aortography often justifies exclusion of selective renal arteriography if major renal artery disease is found.

4. Scrupulous attention to well-established techniques renders these procedures relatively safe.

Table 3

Complications—503 Catheter Arteriograms*

A. Prolonged local hemorrhage (external)	1
B. Large or painful local hematoma	3
C. Transient local petechial hemorrhages—lasting 5 to 7 days (Asymptomatic)	6
D. Transient paresthesias:	
Hand (axillary puncture)	3
Thigh, leg & foot (femoral puncture)	2
E. Loss or decrease in local pulse:	
Transient pulse reduction—lasting 1 to 5 days—(arteriospasm?)	
Femoral	3
Axillary	5
Permanent pulse reduction—thrombosis	
Femoral	2
Axillary	1
Permanent pulse loss—thrombosis	
Femoral	1
Axillary	1
	28

*Cerebral complications not included.

References

1. Dos Santos, R., Lamas, A. & Pereira Caldas, J.: L'Arteriographie Des Membres de L'Aorte et de Ses Branches Abdominales, Bull. Soc. Nat. Chir. 55: 587-601, 1929.
2. Seldinger, S. I.: Catheter Replacement of Needle in Percutaneous Arteriography, Acta Radiol. (Stockh.) 39:368-376, 1953.
3. Evans, J. A. & Tillotson, P. M.: Renal Angiography (Editorial), Radiology 78:975-977, 1962.
4. Sutton, D.: Arteriography, Edinburgh & London, E. & S. Livingstone, Ltd., 1962, pp. 128-159.
5. Amplatz, K.: Assessment of Curable Renovascular Hypertension by Radiographic Technique, Radiology 83:816-829, 1964.
6. Olsson, O.: In Abrams, H. L.: Renal Angiography, Boston, Little, Brown & Co., 1961, 2:539-589.
7. Boijsen, E.: Angiographic Studies of the Anatomy of Single and Multiple Renal Arteries, Acta Radiol. Suppl. 183:1-135, 1959.
8. Edsman, G.: Angionephrography and Suprarenal Angiography, Acta Radiol. Suppl. 155, 1957.
9. Bookstein, J. J. & Stewart, B. H.: Current Status

Figure 6-A

Figure 6-B

Figure 6. (A). Six-year-old male in whose case abdominal roentgenogram indicated a relatively small right kidney and with no urinary tract symptoms. Selective arteriogram consistent with congenital hypoplasia (left renal arteriogram was normal). (B). Forty-five-year-old female with history of repeated urinary tract infections. Small kidney showing irregular atrophic and pitted renal parenchyma consistent with changes of chronic pyelonephritis.

of Renal Arteriography, Radiol. Clin. North America, 11:461-482, 1964.

10. Ranniger, K.: Selective Renal Arteriographic Appearance of Necrotic Hypernephroma. Radiol. 83: 414-418, 1964.
11. Howland, W. J. & Curry, J. L.: Transient Cerebral Blindness: A Hazard of Vertebral Artery Catheterization. Radiol. 83:428-432, 1964.
12. Lang, E. K.: Survey of Complications of Percutaneous Retrograde Arteriography, Radiol. 81:257-263, 1963.
13. Adeney, N. F. & Fraser, G. A.: Renal Angiography by Retrograde Femoral Catheterization as an Aid to Diagnosis of Renal Tumors, Brit. J. Surg. 50:427-431, 1963.
14. Newton, T. B.: Axillary Approach to Arteriography of Aorta and Its Branches, Am. J. Roentgenol. 89: 275-283, 1963.
15. Waldhauser, J. & Klutte, E.: Direct Retrograde Femoral Aortography, New England J. Med. 267: 480-482, 1962.
16. Marshall, T. R. & Ling, J. T.: Direct Percutaneous Noncatheter Left & Right Brachial Angiography, Radiol. 80:258-260, 1963.
17. Uson, A. C., Melicow, M. M. & Lattimer, J. K.: Is Renal Arteriography (Aortography) a Reliable Test in Differential Diagnosis Between Cysts and Neoplasms, J. Urol. 89:554-559, 1963.

Figure 7. (Top). Twenty-one-year-old male with known severe hypertension since age ten showing arteriographic evidence of a sharply defined renal artery stenosis. Hypertension was cured by nephrectomy. (Lower). Thirty-two-year-old female with progressing deep left loin pain of one year's duration. Two renal arteries demonstrated at arteriography with aneurysm of superior artery. Patient's symptoms cured by aneurysmectomy.

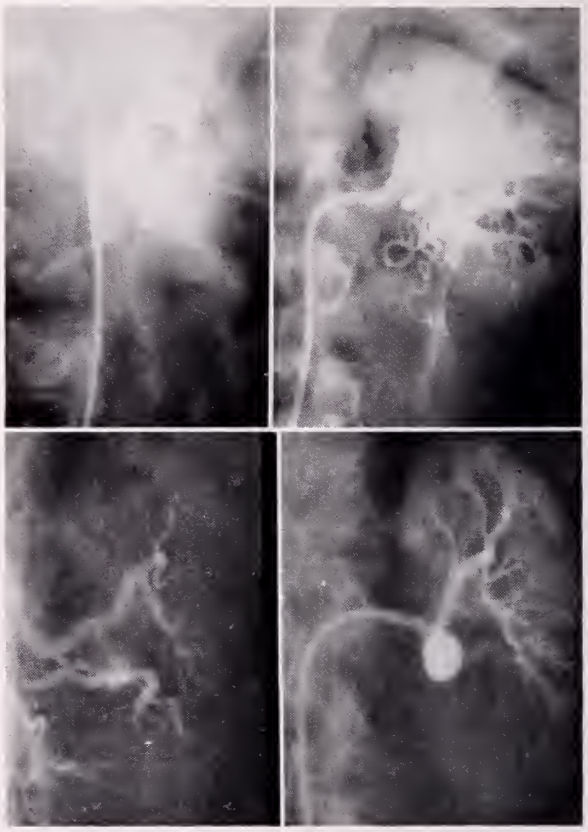

Figure 7

Figure 8-A

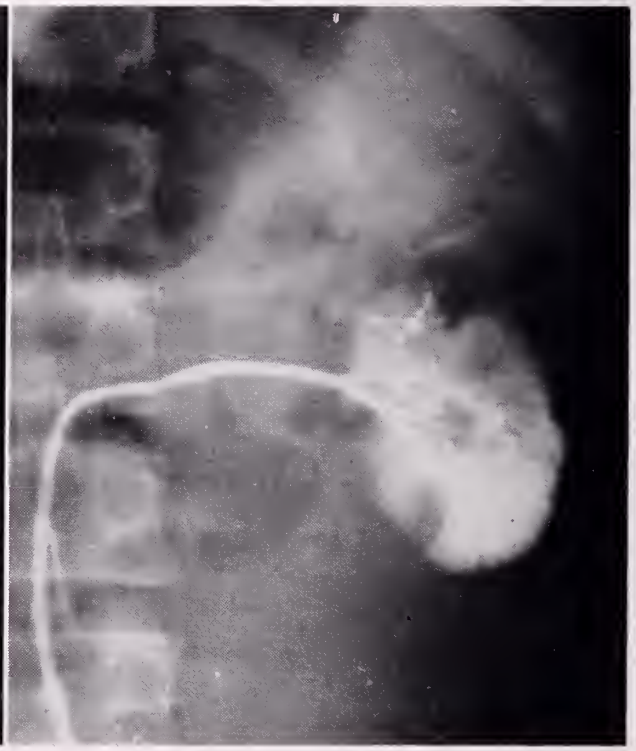

Figure 8-B

Figure 8. (A and B). Selective renal arteriogram in a 17-year-old male ten hours after acute trauma to the left kidney with progressive retroperitoneal bleeding. (A). Urogram consistent with gross hemorrhage obscuring and displacing lower pole of kidney. (B). Two separate left renal arteries shown on aortography with inferior artery selectively catheterized and demonstrating extravasation of opaque medium in lower pole area where a transverse laceration was found and repaired at surgery.

The Prevalence of Infection With The Atypical Mycobacteria in Monongalia County, West Virginia

William C. Stewart, M. D., Susan Gustke, M. D., Henry Carder, M. D., Benjamin M. Stout, M. D., Ernest W. Chick, M. D., and Charles E. Andrews, M. D.

THE reactor rate to tuberculin among children is a good measure of the prevalence of tuberculois in a community. In areas with a low incidence of tuberculosis, skin testing also is an effective case finding technique. With these two objectives in mind a skin testing program in the first, seventh and eleventh grades of the Monongalia County schools was organized in 1962. Intracutaneous tests using Old Tuberculin (OT)* 1:2,000 (5 TU) as an antigen were done on 2,139 children. The tests were read at 48 hours. Any area of induration was measured and recorded, but only a reaction of 5 mm. induration or greater was considered positive. The results of this survey are listed in Table 1. The reactor rates were surprisingly high. A previous study of college freshmen from the same area had shown reactor rates of 2 per cent using purified protein derivative (PPD) as the testing antigen.[1] It was suspected that some of the positive reactions to OT might represent cross-reactions between antigens in the OT and antibodies produced in response to infection by one of the atypical mycobacteria, a group of organisms closely related to *Mycobacterium tuberculosis*. To check the specificity of the reaction, 212 students were retested with PPD intermediate strength (5 TU)+. These students had all reacted to OT with an area of induration although in many instances the area of induration was less than 5 mm. The results of this test are compared with the previously obtained results with OT in Table 2. Fifty students had a reaction of greater than 5 mm. to OT with a reaction of less than 5 mm. to PPD. This suggested that many of the reactions to OT were a result of infection with one of the atypical mycobacteria. Definite conclusions could not be drawn from this study since all students were not tested with both antigens and the two tests were not done at the same time. In order to determine the prevalence in Monongalia County of infection with M. tuberculosis, atypical mycobacteria and *Histoplasma capsulatum* the following study was done.

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Methods

Students in the 1st, 7th and 11th grades in the public and parochial schools of Monongalia County, West Virginia, were selected for study. All students who obtained parental consent for the skin tests were included. Standard antigens made from *M. tuberculosis* (PPD-S)+, *M. kansasii* (PPD-Y)+, Battey strain of Mycobacterium (PPD-B)+, a scotochromgen (PPD-Br)+, and *H. capsulatum* (HKC ± 1:2000)° were used. Syringes used for the different antigens were kept separate to avoid cross-contamination of antigens. Each test done consisted of 0.1 ml. of antigen injected intracutaneously. Each student received three skin tests. All subjects received PPD-S and HKC. Students in each of the three grades were divided into three groups using a table of random numbers. Each group then received one of the antigens derived from the atypical mycobacteria.

The tests were read at 48 hours and recorded as mm. induration. An area of induration of 5 mm. or greater was considered a positive test. All injections and readings were done by the same group of trained investigators.

Results

A summary of the number of students tested and of the results of the tests is given for each antigen by grade in Table 3. A total of 1,670

*Kindly supplied by Dr. N. H. Dyer of the West Virginia State Health Department.

Submitted to the Publication Committee, February 16, 1965.

+Kindly supplied by Dr. Carroll Palmer of the United States Public Health Service.

°Kindly supplied by Dr. Tom D. Y. Chin of the Communicable Disease Center, Kansas City Field Station.

students were included in the survey. Eight hundred sixteen were males and 854 were females. A higher reactor rate was found with each of the antigens from the atypical mycobacteria in every grade when compared with the M. tuberculosis rate for the same grade.

Two hundred seventy-nine students had an area of induration greater than 5 mm. in response to at least one of the mycobacterial antigens. Of these, 23 reacted to two antigens. The size of the reaction to PPD-S is compared to the reaction with the atypical mycobacterial antigen in Table 4. In 10 subjects the PPD-S reaction was the largest while in 12 instances the reaction to the atypical mycobacterial antigen was greater. In one subject the reactions were of equal size. The differences in size of the reaction in the 23 cross-reactors are listed in Table 5. Thus in 13 students the reaction to PPD-S was most likely a cross reaction to one of the atypical antigens. When these 13 results are interpreted as negative reactors to PPD-S and the prevalence rates recalculated the results listed in Table 6 are obtained.

Results of the test with the histoplasmin antigen are listed in Table 3. The 6.6 per cent reactor rate for 11th grade students is essentially the same as the 5 per cent rate previously found for college freshmen from Monongalia County.[1] When the home address of the children who had positive reactions to the HKC antigen was plotted on a map of the county, no clustering was found. On this basis no spot source of infection with the fungus could be located.

Table 1

Reactor Rates 1962

(Old Tuberculin 1:2,000)

Grade	*No. Tested*	*% Pos.*
1st	826	1.4
7th	840	5.2
11th	473	9.5

Table 2

Comparison of Results of Skin Tests With OT and PPD

(212 Students)

		OT (5 TU)	
		Not Sig.	*Sig.*
PPD (5 TU)	Not Sig.	131	50
	Sig.	9	22

Significant reaction = 5 mm. or more in duration.

Table 3

Results of Skin Testing Program 1963-64

Test Antigen	*Total Tested*	*Number Positive*	*Per Cent Positive*	*Grade*
PPD-S	666	4	0.6	1
	714	9	1.3	7
	290	15	5.2	11
PPD-B	223	29	13.0	1
	231	39	16.9	7
	92	21	22.8	11
PPD-Br	227	37	16.6	1
	246	88	35.7	7
	101	42	41.5	11
PPD-Y	216	4	1.8	1
	237	8	3.4	7
	97	6	6.2	11
HKC	662	12	1.8	1
	643	43	6.7	7
	274	18	6.6	11

PPD-S—antigen prepared from *M. tuberculosis;*
PPD-B—from a Battey strain of Mycobacteria;
PPD-Br—from the Bridges strain, a scotochromogen;
PPD-Y—from *M. kansasii;*
HKC—from *H. capsulatum.*

Table 4

Cross-Reactions

(Number of Students)

PPD-S	*PPD-B*	*PPD-Br*	*PPD-Y*
Greater than	0	5	5
Less than	3	5	4
Equal	0	0	1

Table 5

Differences in Size of Reactions

(23 Students With Cross-Reactions)

PPD-S	*PPD-B*	*PPD-Br*	*PPD-Y*
Equal size	0	0	1
1 mm. difference	0	0	0
2 mm. difference	2	2	5
3 mm. difference	0	1	1
Greater than 3 mm. difference	1	7	3

Table 6

Reactor Rates to PPD-S

	Original Reactors		*Minus Cross-Reactors*	
Grade	*Number Positive*	*Per Cent Positive*	*Number Positive*	*Per Cent Positive*
1	4	0.6	1	0.1
7	9	1.3	7	0.9
11	15	5.2	9	3.1

Table 7

	Number Tested	*Number > 10 mm.*	*Per Cent Positive*	*Grade*
PPD-S	666	0	0	1
	714	5	0.7	7
	290	7	2.4	11
PPD-B	223	6	2.7	1
	231	20	8.7	7
	92	6	6.5	11
PPD-Br	227	15	6.6	1
	246	47	19.1	7
	101	25	24.7	11
PPD-Y	216	0	0	1
	237	2	0.8	7
	97	4	4.1	11

Discussion

Bacteria of the genus Mycobacterium are widespread in nature, having been isolated from soil, water, milk, fish, animals and man. *Mycobacterium tuberculosis var. hominis* is the most important organism of this group in so far as disease in man is concerned. Since the report of Buhler and Pollak,[2] it has become increasingly evident that other mycobacteria are an important source of disease in humans. The organisms form a heterogeneous group and separation of them into clearly defined species has not been possible. The classification offered by Runyon[3] based on colonial morphology, rate of growth, and pigmentation has proven useful: Group I, the photochromogens (now recognized as a specific species *M. kansasii*); Group II, the scotochromogens; Group III, nonchromogenic and Group IV, the "rapid-growers." Isolation of these organisms from resected pulmonary tissue and lymph nodes has confirmed their disease-producing capability. The significance of the isolation of one of these organisms from the sputum of a patient is not always clear. In general, Group I organisms are thought always to represent pathogens and are considered responsible for any pulmonary lesions present, while Groups II and III organisms either may cause pulmonary disease or be merely opportunists in an already diseased lung.

The geographic distribution of these organisms shows variation from group to group. In the southeastern states, Group III organisms have been found almost exclusively.[4] In the midwest, principally Dallas, Houston, Chicago and Kansas City, Group I organisms are found.[5] This distribution pattern is based primarily on studies of patients and the organisms isolated from them, as well as population surveys using skin tests with antigens from the various mycobacteria. Organisms from Groups II and IV have been isolated throughout the United States and, as yet, no specific distribution pattern has been found.

The validity of conclusions based on skin test data in regard to the prevalence of a specific infection in a population is dependent upon the specificity of the antigen used. Edwards[6] *et al* have injected guinea pigs with a variety of strains of the unclassified mycobacteria and subsequently have skin tested the animals with both the infecting strain and related organisms. Reactions to the homologous antigen were large, comparable in size to those obtained with tuberculin in animals infected with *M. tuberculosis*, while reactions of animals infected with other organisms to heterologous antigens were considerably smaller and varied with the different infections. Edwards and Palmer,[7] in another study, compared reactions with PPD-S and PPD-Y or PPD-B in patients infected with typical tubercle bacilli, the Battey organism or a photochromogen. Of the patients infected with typical *M. tuberculosis*, 97.2 per cent had a reaction of 6 mm. or more to PPD-S while 44.8 per cent reacted to PPD-B. The mean size of the reaction to PPD-S was 16.2 mm. and to the PPD-B 6.2 mm. Thus, while cross-reactions did occur, the two groups could be separated on the basis of the size of the reaction to the antigen. Ninety per cent of the patients with a photochromogen infection reacted to PPD-Y while 83.9 per cent reacted to PPD-S. The mean size of the reaction in the photochromogen group was 14.0 mm. to PPD-S and 14.3 mm. to PPD-Y. In the patients with tuberculosis the mean size of the reaction was 16.7 mm. to PPD-S and 13.4 mm. to PPD-Y. These and other similar studies indicate that a homologous antigen usually gives a larger reaction than closely related antigens but that cross-reactions are frequent. Frequency distribution curves of the size of reaction plotted against the number positive in the above studies indicate that the homologous antigen usually gives a reaction of 10 mm. or greater. Table 7 summarizes the number of reactors to each mycobacterial antigen in this study, using 10 mm. as a positive reaction. The total number of reactors is decreased, but the interantigen relations remain unchanged.

This study gives only an approximation of prevalence rates of infection with the atypical mycobacteria. The population studied was a group not chosen at random but according to whether or not the child's parent gave permission for the tests. How the sample studied might differ from the total population is unknown. Only approximately one-third of the students enrolled in the 11th grade were included.

Every student was not tested with all the available atypical antigens. The results obtained probably represent the true incidence of infection in the population studied since the tests were allotted on a random basis. It cannot be determined from this study whether or not the infection was acquired in Monongalia County since complete residence data are not available from each student.

A follow-up chest x-ray examination was obtained by the Monongalia County Health Department on all 27 students who reacted to tuberculin. Two children had changes consistent with old, inactive childhood infection and one had changes consistent with previous histoplasmosis

infection. No cases of active tuberculosis were uncovered by the survey.

Purified protein derivative is the antigen of choice for skin test surveys for tuberculosis. This study, as well as others, indicates fewer false positive reactions, i.e., cross-reactions will be obtained with this antigen.[8] It is highly desirable to use all available atypical mycobacterial antigens in prevalence studies. For case finding activities, however, it is adequate to use intermediate strength PPD as the test antigen and to concentrate follow-up activities toward those individuals with a reaction of greater than 10 mm. of induration.

Summary

A skin test survey of school children in Monongalia County using old tuberclin as the antigen indicated that infection with the atypical mycobacteria probably was prevalent. To test this finding a second survey was done using antigens derived from the atypical mycobacteria as well as standard tuberculin and histoplasmin. The reactor rates to tuberculin were as follows: First grade 0.6 per cent, seventh grade 1.3 per cent, and eleventh grade 5.2 per cent. In every grade the unclassified mycobacterial antigens gave higher reactor rates. It was concluded that many of the reactions to PPD-S represented cross-reactions. If 10 mm. is accepted as a positive reaction rather than 5 mm. most of the cross-reactors will be eliminated. Further studies should then be carried out in this group and their close contacts to find active cases of tuberculosis.

Acknowledgment

The authors wish to thank the nurses of the Monongalia County Health Department for their invaluable help in making this study possible.

References

1. Andrews, C. E., Lawless, J. J. & Ruggerio, J.: Histoplasmin Sensitivity in West Virginia, Am. Rev. Resp. Dis. 89:409, 1964.
2. Buhler, V. B. & Pallak, A.: Human Infection With Atypical Acid Fast Organisms: Report of two cases with pathologic findings. Am. J. Clin. Path. 23:363, 1953.
3. Timpe, A. & Runyon, E. H.: Relationship of "Atypical" Acid-Fast Bacteria to Human Disease: Preliminary report. J. Lab. & Clin. Med. 44:202, 1954.
4. Lewis, A. J., Jr., Lasche, E. M., Armstrong, A. L. & Dunbar, F. P.: A Clinical Study of the Chronic Lung Disease Due to Nonphotochromogenic Acid-Fast Bacilli, Ann. Int. Med. 53:273, 1960.
5. Lester, W., Jr., Botkin, J. & Coton, R.: An Analysis of 49 Cases of Pulmonary Disease Caused by Photochromogenic Mycobacteria. Transactions of the Seventeenth Conference on the Chemotherapy of Tuberculosis, Veterans Administration—Armed Forces, 1958, pp. 289-297.
6. Edwards, L. B., Palmer, C. E., Affronti, L. F., Hopwood, L. & Edwards, P. Q.: Epidemiologic Studies on Tuberculin Sensitivity, Am. J. Hyg. 71:218, 1960.
7. Edwards, L. B. & Palmer, C. E.: Epidemiologic Studies of Tuberculin Sensitivity. I. Preliminary Results With Purified Protein Derivatives Prepared from Atypical Acid-Fast Organism, Am. J. Hyg. 68:213, 1958.
8. Edwards, L. B.: Current Status of the Tuberculin Test, Ann. Acad. Sci. 106:36, 1963.

Drug Serendipity

SERENDIPITY has always provided some of the greatest discoveries. Search for a seasickness remedy produced the antihistamines. Investigation of a hiccough remedy yielded a potent analgesic. Subsequently, the antihistamines were discovered to be antinauseants; then tranquilizers. Snake venoms, studied for the treatment of arthritis, were found to be anticoagulants and fungicides. The combined study of anti-bacterial drugs and cabbage feeding led to the antithyroid drugs. From these, it can be seen that the ultimate destiny of a new drug is not always predictable until its use is widespread.—A. Lee Lichtman, M. D., in *Experimental Medicine and Surgery.*

The Influence of Diet Prescriptions and Instruction Materials on the Diabetic Patient's Dietary Adherence

Margaret A. Wilson, Ph. D.

While numerous factors influence the diabetic patient's adherence to his diet, especially important are the effect of the diet prescription on the character of the resulting diet, and the appropriateness of the content of the diet instruction materials.

The Diet Prescription

Aside from the assignment of quantities of protein, carbohydrate and calories to meet the unique physiological status of the individual diabetic, consideration needs to be given to the patient's dietary and socio-economic status if the prescription is to contribute to the patient's adherence to his diet.

Belief that the patient will accept any prescribed diet on an intellectual basis, that is, an explanation or statement of its need, is recognized as inadequate by those experienced in diabetic education. Few individuals will change permanently a lifetime of eating habits because they are told it will be best for them, unless the change also fits into their life pattern. For example, a prescription of 100 Gm. of protein for the patient who cannot afford the quantities of milk and meat exchanges required to fill that order, or for the patient who intensely dislikes all forms of milk and eats little meat, points the patient in the direction of dietary indiscretion.

Another example is that prescribing carbohydrate greater by 30-45 Gm. than an alternative order, appropriate in the control of a given patient, may make it possible for him to have a volume of sandwiches at noon and potatoes at dinner similar to that which he is accustomed to eating, making the diet more acceptable and adherence more feasible.

Putting most overweight male diabetic patients on 1,800 calories simplifies the task of the prescriber, but does not help all of those men to adhere to the diet. For the patient whose history shows an intake indicating he could reduce appropriately on 2,000 or 2,200 or more calories, the extra 200-400 calories well may make the difference between satisfaction and dissatisfaction, between following and not following the diet.

Submitted to the Publication Committee, November 4, 1964.

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Even the division of the carbohydrate in relation to the hypoglycemic agent needs adjusting with individuality to yield a diet pattern acceptable to the patient. For example, the 2/7 carbohydrate breakfast frequently used may mean a rather large quantity of food for many individuals who would prefer larger bedtime and mid-morning snacks. Few patients are given calorie containing mid-morning snacks, yet this is feasible; and many individuals have been accustomed to them in their pre-diabetic period.

Food Intake a Complexity

Food intake is highly personal, charged with psychological bonds, influenced by economics, and related closely to life's various activities. A detailed history of the patient's dietary habits and related factors, with an evaluation of the protein, carbohydrate and caloric intake constitute essential basic information to be considered in the formulation of a realistic prescription which encourages the patient to adhere to his diet.

None of the foregoing implies that the resulting diet will be everything the patient had or would desire, for certain restrictions are necessary because of his diabetic status, but individualization in dietary prescription can contribute to dietary adherence.

The Diet Instruction Material

One diabetic diet instruction form is not adequate for teaching all diabetic patients since they, as do other individuals, vary greatly in their capacity to comprehend, to learn, and to accept. Accordingly, the West Virginia University Medical Center Dietetic Staff* has developed

*The comprehensive and simplified forms are largely the creation of Jane Jordan Nelson, previously a medical dietitian at the Medical Center. Their use was approved by the medical staff.

three forms: the basic, the comprehensive, and the simplified.

The Basic Form

The basic form is essentially the diet exchange system developed a number of years ago by representatives of the American Diabetes Association, Inc., The American Dietetic Association, and the U. S. Public Health Service. The latter form is used in the majority of American hospitals and often is referred to as the A.D.A. form. This system consists of food exchange lists. Each list contains foods which, in the stated volumes, have approximately the same protein, fat and carbohydrate value and an approximate equivalence of other nutrients so that they can be exchanged one for another.

In developing the West Virginia University basic form, additions included the hamburger and wiener buns and potato chips which contribute to the ease and joy of eating out; the salt pork so widely used by West Virginians; the American favorites—French fries, pancakes, popcorn and dietetic soft drinks as well as other items. All help to provide a diet more compatible with American eating habits.

While an appropriate instructional tool for large numbers of diabetic patients, the basic form remains restrictive since the foods are kept within the separate exchange lists, with the exception of bread exchanges such as French fries and ice cream which require omission of fat exchanges.

The Comprehensive Form

The comprehensive form provides a wider variety of food, more flexibility, and a more normal diet for those who can handle its complexity. This form retains the food exchange system lists, but in almost every list new foods have been added. Use of the form requires the patient to be able to choose an exchange from one list and to alter the number of exchanges in another list according to starred footnotes. For example, ⅛ of a 14″ pizza is listed as a meat exchange, but the patient also must omit 1½ bread exchange.

Handling this type of complexity is too difficult for many patients. The addition, however, of commercial soups, chili, pie crust, sweetened gingerale and gelatin, doughnuts without sugar coating, ice cream cones, and other common American foods adds enjoyment for the patient who can handle this diet. It also makes his dietary adherence more feasible.

Having a doughnut without sugar coating as part of the diet, for some patients, might be one step away from a doughnut with sugar coating. The patient instructed on the comprehensive form must have the ability to understand the importance of not taking that step.

The West Virginia University Medical Center staff restricts the use of this form to patients who have an education indicative of ability to start on it rather than on the basic form, and to patients who have proven to the medical dietitian that they understand and can handle the basic form, and are able to go beyond it. There is, however, an advantage in starting the patient on a given form and keeping him on it, rather than switching to a second form and having to attempt to undo some of the earlier teachings.

Use of the comprehensive form also is restricted to diabetic patients whose weight is satisfactory for it is possible, theoretically, that the taste of sweets (such as the sweetened gingerale and the popsicle) on a physiological as well as on a psychological basis, may lead the obese patient to desire more sweets, thus forming an anti-adherence factor in dietary treatment.

The Simplified Form

The basic form is too complex for many patients and the simplified form was developed for those with limited ability to comprehend, and for those with restricted finances. The simplified form offers a way to provide relatively controlled carbohydrate and caloric values while contributing to increased patient comprehension and adherence.

The simplified form does not follow the food exchange lists found in the basic and comprehensive forms. In fact the term "food exchange," developed in the A.D.A. form, is replaced with the term "food group," for the former term has proven confusing to many patients.

While the food exchange lists of the A.D.A., basic, and comprehensive forms are identified as having specific values of protein, fat and carbohydrate, it is important to remember that the foods in any exchange list actually vary considerably one from another in these values, and from the stated values of the exchange lists. In the simplified form the same thing is true. For example, both in the exchange system forms (A.D.A., basic and comprehensive) and the group system form (simplified) the bread list is assigned the values (approximate) of 2 Gm. protein and 15 Gm. carbohydrate. Actually the values of the items in the list vary as much as 1-10 Gm. of protein, 1-11 Gm of fat, and 6-26 Gm. of carbohydrate. This is acceptable.

The exchange system forms contain eight food lists:

List	*Protein (Gm.)*	*Fat (Gm.)*	*Carbohydrate (Gm.)*
Milk	8	10	12
Fruit	—	—	10
Bread	2	—	15
Vegetable "A"	1	—	3
Vegetable "B"	2	—	7
Meat	7	5	—
Fat	—	5	—
Free foods	—	—	—

In contrast the food group system form contains six food lists:

List	*Protein (Gm.)*	*Fat (Gm.)*	*Carbohydrate (Gm.)*
Protein	9	5	15
Bread	2	—	15
Vegetable	1	—	3
Fruit	—	—	10
Fat	—	5	—
Free foods	—	—	—

Comparison of the above sets of lists shows obvious differences in the vegetable and protein lists.

Vegetable Group.—The simplified form has only one vegetable group. This was developed by moving the exchange system "B" vegetables having a high carbohydrate content (beets, onions, green peas, winter squash) to the bread list, and placing those with the lower carbohydrate values (carrots, rutabaga, turnips) with the exchange system vegetable "A" list to form the single vegetable group. The carbohydrate range in the vegetable and bread groups thus developed is acceptable, and the simplification can lead to increased patient comprehension and adherence.

Protein Group.—Instead of the milk and meat lists of the exchange system, there is a protein group. This contains milk, meat, eggs, cheese and legumes, as seen in Table 1.

Table 1

The Simplified Form Protein List

Protein Group (Prot. 9 Gm.; Fat 5 Gm.; CHO 15 Gm.)
One serving is:

*Cheese	1 ounce
*Cottage Cheese	¼ cup
Dried beans and peas (cooked)	½ cup
Egg	1
*Meat, Poultry and Fish (beef, chicken, fish, ham, lamb, liver, luncheon meat, pork, sausage, wiener)	1 ounce
Milk (evaporated)	½ cup
Milk (dry powdered)	¼ cup
Milk (whole, skim, buttermilk)	1 cup
Peanut Butter	2 tablespoons

*Add 1 bread group serving

The protein list items have an assigned value equivalent to the combination of one meat and one bread from the exchange system; and the form indicates that when cheese, egg or meat is selected, one serving from the bread group is to be added.

If the patient is obese, he probably should be taught to use the skimmed milk; otherwise, the variation in the fat content of the items is of little importance.

In the meat exchange list the volume of peanut butter eaten daily is restricted because of its carbohydrate content but in the simplified form this restriction is unnecessary because of the carbohydrate value asigned to the protein group.

A major value of the protein group formation is that the combination of the foods in it aids the patient in obtaining his protein needs in a more economical manner than is possible with the exchange system. The latter often makes it almost impossible for patients with extremely limited finances to adhere to a diabetic diet and to obtain an adequate nutritional intake.

With the combination of milk, meat and legumes in the protein group, however, it is important to encourage the patient to use two or more servings of milk and/or cheese whenever he can because as with any form, instruction should be given in obtaining adequate nutrient intake.

Simplification also extends to the contents of the remaining groups.

Fruit Group.—In the exchange system the volume of the fruits yielding the assigned value of 10 Gm. of carbohydrate varies considerably, i.e., grape juice 1/4 cup, pineapple juice 1/3 cup, and blueberries 2/3 cup. Manipulation of these fractions is confusing to many patients. In the simplified form fruit and fruit juice servings are listed as 1/2 cup, with the exception of the few items which can be counted easily, as one medium peach or two prunes. While this widens (acceptably) the range of actual carbohydrate content of the list items, the list can be understood by the more "limited" patient with the result that he follows it more adequately than the confusing fractions of an exchange system form.

In addition, some of the more expensive or less available fruits have been omitted from the list.

Bread Group.—The variation of cereal portions found in the exchange system has been modified to 1/2 cup both for dry and cooked cereal, and 4 crackers equal a serving.

Omitted are expensive items such as potato chips, but hamburger and wiener buns (which

are not inexpensive) are included as items less costly than many for the patient who must eat in restaurants.

Ice cream, a luxury to some, is included since it is made at home by many people with limited finances. No attempt is made to compensate for the extra fat in such foods as ice cream, for the fluctuation of fat in such protein group foods as legumes and meat will balance the total as the patient's choices in this group vary.

Commodity products can be utilized in the included biscuits, cornbread and pancakes loved by many West Virginians. Flour is listed, and instruction in its use is dependent on such things as the individual's method of making the gravy used so extensively by those with limited money.

Fat Group.—Some expensive items like cream cheese and olives, listed in the exchange system, have been removed but butter is retained for patients who churn their own, or receive it with commodity products. Salt pork is included because of its traditional use in West Virginia cooking. To make the form appropriate for many patients, various included foods are appropriate for use by those in different levels and types of financial difficulty.

Free Food Group.—The only change from the exchange system is the omission of the expensive dietetic soft drinks.

General Comments

The simplified form is not appropriate for patients who can follow intelligently the basic or the comprehensive form. By using these they obtain a more accurately controlled intake than they would with the simplified form.

The patient with limited comprehension or finances, or both, however, can gain more accurate control of intake by using the simplified form which he can understand and which relates well to his financial status, than when he loses his way in an attempt to follow the more complex forms which are unsuited to his needs.

The three forms meet the needs of the majority of patients. For some, however, even the simplified form is too complex and it is necessary to prepare an even more simple and individualized diet guide. It may be necessary to indicate the exact foods to be eaten each meal. For example, for breakfast: "1/2 cup oatmeal," "1 slice bread." For the patient needing this kind of help it often means leaving his diet very much as his diet history has shown it to be, concentrating on the omission of items such as sugar and cake, and emphasizing consistency from day to day. Then manipulation of other aspects of treatment to yield the greatest possible control can bring greater achievement than will be possible if greater change or more complexity of diet is attempted.

While it is best to start the patient on the form on which he will remain, patients instructed before the development of the three West Virginia University forms may need transferring. Also, some patients who are started on the basic form may prove to be candidates for the comprehensive form or the simplified one.

Successful adherence to his diet by the diabetic patient is due in large part to his thorough understanding of the diet and the manner in which it can fit into his life pattern. The simplified form can facilitate comprehension and reduce the negative influence of a restricted budget for the "limited" patient. While the comprehensive form is more complex than the basic one, it can be handled easily by the patient possessing increased ability, and its flexibility and increased variety of food offer that individual greater freedom.

The three forms, appropriately used as instruction material, can contribute vitally to dietary adherence by the diabetic patient as can the influence of an effectively written diet prescription.

A liberal is a man too broadminded to take his own side in a quarrel.

ROBERT FROST.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 26-28, 1965

Plan to Attend — Make Your Reservation . . . Now !

LOMOTIL *Pharmacologic Activity*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

LOMOTIL®

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)

atropine sulfate . . . . . 0.025 mg.

tablets • liquid

slows propulsion

relieves distress

stops diarrhea

Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

The President's Page

VALEDICTORY

"Honour a physician with the honour due unto him for the uses which ye may have of him: for the Lord hath created him. For of the most High cometh healing, and he shall receive honour of the kind. The skill of the physician shall lift up his head: and in the sight of great men he shall be in admiration."

—Apocrypha: Ecclesiasticus, xxxviii, 1-3.

As I come to the end of this presidential term, I look back on a year of crisis filled with many memories, which I shall never forget. The honor of being the President of the West Virginia State Medical Association entails much hard work, many miles of travel in our State and Country and many sleepless nights—truly a distinctive honor and an unforgettable experience, which is not all pleasure.

As I met with you at your County Medical Society meetings, I felt a deep pride in medicine and in each of you, as you showed the love and devotion to this profession, which is so characteristic of physicians. I saw our medical school and its faculty in operation, your hospitals, and your area of practice in the communities of our State. I met with Governor Smith about medical matters and talked with the leaders of our American Medical Association about our problems. Because of this, I got to know Drs. Appel, Ward and Annis and we discussed you and this socialistic scheme at great lengths. I was quite impressed with this year's American Medical Association Inaugural Ceremony where I was privileged along with other State Presidents to sit on the rostrum and be introduced.

Yes, at times I belabored H.R. 6675, but it was uppermost upon my mind. With its passage, the House of Delegates of the American Medical Association will hold a special meeting and further action will be forthcoming at our meeting at The Greenbrier. I urge you to re-read on page 178 in the July 1965 issue of *The West Virginia Medical Journal* the Resolution, "Preserving the Freedom and Quality of Patient Care."

As I journeyed to adjoining states, I learned much of their problems and their methods of resolving them, which has been an invaluable aid to us in this year of crisis and financial difficulties. I regret the inability to have a meeting of County Medical Society and Auxiliary officers with your State Medical Association officers and urge that this be arranged as soon as possible. I also believe that a meeting of the chairmen of each of your Association Committees with your officers is needed.

As I leave you now, after this difficult year, I want to express my sincere appreciation to all of you who have made it in some way enjoyable—to the members of our wonderful Auxiliary and its Officers, to each of the Officers of the Component Societies, to the various Chairmen and committee members of the State Medical Association, to all our devoted members of Council, to our excellent Central Office Staff and to my many colleagues for their kindness and devotion to medicine, who took care of my patients while I was out of town.

As I return to my family and practice, I shall cherish these many memories.

To my successor, Dr. Seigle W. Parks, I wish much luck and success in the year ahead and pledge our wholehearted support.

Might I urge you again to send in your reservations to The Greenbrier so that we may all share men like Appel, Annis, Judd and the many others whom we have worked so hard to bring to you.

As I come to the close of this Valedictory, I can think of no better ending than to quote Henry Van Dyke: *"There is a loftier ambition than merely to stand high in the world. It is to stoop down and lift mankind a little higher."*

Albert C. Esposito

Albert C. Esposito, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

98th ANNUAL MEETING AT THE GREENBRIER

Members of the Program Committee and officers deserve a pat on the back for a job well done in arranging the program for the 98th Annual Meeting at The Greenbrier later this month. Dr. Richard J. Stevens and the members of his Committee have succeeded in lining up an impressive list of distinguished physicians and surgeons for the scientific sessions and also were successful in their efforts to obtain outstanding honor guests as speakers at sessions of the House of Delegates and other non-scientific functions.

Seldom will physicians and their wives have an opportunity within a two-day period to hear addresses by the following three men who are acknowledged to be the leading spokesmen for the medical profession:

Dr. James Z. Appel of Lancaster, Pennsylvania, President of the American Medical Association.

Dr. Edward R. Annis of Miami, Florida, a past president of the American Medical Association.

Dr. Walter H. Judd, former medical missionary and congressman from Minnesota.

Doctor Appel will speak at the first session of the House of Delegates on Wednesday afternoon, August 25, and Doctor Judd will be the first speaker at the general session on Thursday morning, August 26. Doctor Annis will deliver

Albert C. Esposito, M. D.
President

an address at a WESPAC meeting on Thursday night.

These three physicians have been engaged in the struggle to preserve the freedom of medicine and will be in a position to give us their views on what lies ahead for the practicing physician. We can look to them for expert guidance and counsel in this crucial period for American medicine.

It should be noted that Dr. Albert C. Esposito, our own State President, deserves a great deal of credit for his leadership during the past twelve months. He has traveled extensively throughout the State and served as our representative to numerous regional and national meetings throughout the country.

We know that Doctor Esposito's messages appearing on the "President's Page" in *The Journal*, together with frequent appeals to the members, served to arouse the interest of many in legislation on the state and national levels. He has proved a most capable officer and we are pleased that he will continue his role of leadership as Chairman of the Council during the coming year.

Doctor Esposito will present his Presidential Address at the second and final session of the House of Delegates on Saturday afternoon, August 28. His address will be the climax to a convention which most certainly should appeal to every physician in the State.

Members of the Woman's Auxiliary and guests have been cordially invited by the Program Committee to hear the addresses by Drs. Appel, Annis, Judd and Esposito.

General scientific sessions will be held on Thursday, Friday and Saturday mornings, while meetings of sections and affiliated societies will be held during the afternoon hours.

One of the features will be a Clinical Pathological Conference which will be presented as a part of the scientific program at the second general session on Friday morning, August 27. The CPC undoubtedly will add much to the scientific program and Dr. Leon Schiff of Cincinnati has agreed to serve as the Clinical Discussant. A protocol for the CPC was inserted in a Convention Bulletin mailed to all members in July and additional copies will be available at The Greenbrier.

Credit for arranging the conference belongs to several staff members at Charleston Memorial Hospital. The moderator will be Dr. Kenneth G. MacDonald and the pathologic and radiologic findings will be presented by Drs. Grover B. Swoyer, and J. Dennis Kugel, respectively.

Attendance at an annual meeting would not be complete without setting aside a few hours to visit the exhibits which will be housed in the Exhibit Center. A large number of scientific exhibits representing medical research will be on display, together with the interesting and educational industrial exhibits. Representatives of the Industrial Exhibitors always welcome visits by physicians at their booths and are in attendance at the meeting specifically for the purpose of discussing new products recently placed on the market by their firms.

On the lighter side, the Auxiliary will sponsor a Cabaret Dance on Friday evening, and a reception honoring the officers of the State Medical Association will be held on Saturday evening. All persons in attendance at the Convention are cordially invited to attend these two functions.

Please take time to make your reservation at The Greenbrier if you have not already done so. It is anticipated that more than 700 persons will be in attendance and an advance reservation will assure you that you and the members of your families will have room accommodations at this beautiful resort hotel.

We'll see you at The Greenbrier!

REPORT OF THE EDITORIAL BOARD

The report of the Publication Committee for the year 1964 is submitted for the consideration of the Members, Council and Delegates of the West Virginia State Medical Association. During 1964, *The West Virginia Medical Journal* published 28 scientific articles; of these, 15 papers were written by in-state authors and 13 by out-of-state guests. There were 15 special articles dealing with medical problems peculiar to West Virginia.

The Journal contained a news section averaging 15 pages per issue. This is the largest news coverage of any State Medical Journal of comparative membership. This is an important feature of *The Journal* and contributes the only permanent record and history of the Association. At this time we have no field representative in our State Medical Association and the only regular contact of the component society or individual member with state business is via the councilor or *The Journal*.

The By-Laws state "the Publication Committee shall have the power to carry on the busi-

ness of publishing *The Journal* during each calendar year." So it seems the Committee must be concerned about the financial difficulties of *The Journal*. The 1964 Audit shows a deficit in the Journal fund of $12,234.48; however, there is a carry-over deficit of $2,803.29 which, in our opinion, should not be a part of the 1964 Audit. There is now an allocation of funds of $3.50 per active member for subscription dues which on the basis of 1,300 active members amounts to $4,350.00. If these two items are properly considered, the deficit is actually $5,171.19. *The Journal* absorbs $6,498.32 of the operating expenses of the headquarters office by the allocation of this sum for management and editing. Without a journal this expense would remain materially the same and would be added to the cost of the Charleston office. Also, it would increase the deficit of the General Fund by the above amount. Subscribers are reminded that before the curtailment of national drug advertising, *The Journal* contributed generously to the General Fund. In 1959, $8,500.00 was transferred from the Journal Fund to the General and Public Service funds. In 1960, $5,000.00 was transferred to the General Fund. Advertising income is now increasing but it is too early to predict that *The Journal* may ever contribute again to the financial support of the headquarters office.

Some expenses may be lowered through different business operations. This is a matter for the Financial Committee to decide; however, any such saving will be minimal and may be offset by operating inconvenience. Some local advertising may be secured through the advertising media in the State, by paid solicitation, or through the assistance of component societies. National advertising is dependent on national factors. Every physician has a national contact through the drug detail man, and physicians might urge these representatives to request their companies to insert advertising in our State Journal. A list of our advertisers is prominently displayed on the left inside back cover of each issue.

Changes in the professional makeup for 1965-66 have been discussed and some may be ready for publication in the near future. *The Journal* hopes to have a monthly page on x-ray interpretation during the coming year. There is a plan for publication of a case history or CPC every quarter. A page of information containing reports of non-released drugs may soon become available to us. A progress report on clinical and laboratory medicine would be a most welcome feature (do we have any volunteers?). The Committee suggests to the county societies that a brief report on medical activities in the area would be more interesting than the usual account of regular monthly meetings. A similar recommendation could be given to the Woman's Auxiliary. The Publication Committee would consider an allotment of a page or portion thereof to the Auxiliary for reporting interesting observations or happenings with the exclusion of vital statistics.

The Journal has been requested to publish the medical releases of some of the voluntary health agencies. These reports are excellent and some of them will be published as space permits. *The Journal* cannot discriminate between health agencies and will have to use such information on a rotational basis.

The basic purpose of *The Journal* is the dissemination of scientific information. *The Journal* will continue to publish three to five articles per issue. Outstanding papers by star performers are given preference but the Committee has an obligation to accept articles from house officers and students if the papers are well-written reports of supervised clinical or laboratory studies. All papers must receive the approval of a majority of the Publication Committee. The sections on general news, special articles and features will be expanded as income increases from advertising or direct appropriation.

Comments and criticism from physicians in the form of letters to the editor are always welcome.

George F. Evans, M. D.
Editor
Halvard Wanger, M. D.
Charles L. Goodhand, M. D.
E. Lyle Gage, M. D.
E. J. Van Liere, M. D.
D. E. Greeneltch, M. D.
William L. Cooke, M. D.

Wanted—Physicians for Drug Research

It is common knowledge that the pharmaceutical industry is faced with a significant issue in the shortage of qualified investigators. Drugs are becoming more and more complex and the use of the general doctor, without specific experience in clinical investigation, in testing drugs in his office in the midst of a busy practice is probably coming to an end.

The need for training of physicians in the drug field has reached a critical stage, and this problem must be met by the joint efforts of government, industry, and the scientific community.—Joseph F. Sadusk, Jr., M. D., in Bulletin of the American College of Physicians.

GENERAL NEWS

Distinguished Guests To Attend Annual Meeting, Aug. 26-28

Three honor guests head a long list of distinguished physicians and surgeons who will appear as speakers at the 98th Annual Meeting of the West Virginia State

James Z. Appel, M. D.
AMA President

Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee, announced that the following physicians will be among the speakers at the three-day meeting: Dr. James Z. Appel, President of the American Medical Association; Dr. Edward R. Annis, a Past President of the American Medical Association; and Dr. Walter H. Judd, former medical missionary and congressman from Minnesota.

Doctor Appel was installed as President of the American Medical Association during the Annual Convention in New York City in June. A practicing physician in Lancaster, Pennsylvania, he was first elected a Delegate to the AMA House of Delegates in 1945 and served for seven years as a member of the Board of Trustees. He served as vice chairman of the Board for two years, a position he relinquished upon being named President Elect at the 1964 clinical convention in Miami Beach.

Doctor Appel will be the guest speaker before the first session of the House of Delegates on Wednesday afternoon, August 25. His address will be heard shortly after the House convenes at three o'clock.

Address by Dr. Walter H. Judd

Doctor Judd will deliver an address at the first general scientific session on Thursday morning, August 26. His subject will be "What is Ahead for the Doctor?"

Doctor Judd served as a medical missionary in China and returned to this country in 1938. He spent the next two years speaking throughout the United States in an attempt to arouse Americans to the menace of Japanese military expansion and the threat to world peace of communist subversion in China.

He served 10 terms in the House of Representatives and is a nationally recognized authority on U. S. foreign policy. More than 20 universities have conferred on Doctor Judd honorary doctorate degrees and he was the recipient of the AMA Distinguished Service Award in 1961.

Doctor Annis to Speak on Thursday Night

Dr. Edward R. Annis of Miami, Florida, a Past President of the American Medical Association and one of the leading spokesmen for the medical profession, will be the speaker at a WESPAC meeting which will be held on Thursday night, beginning at nine-thirty o'clock.

During the past five years Doctor Annis has devoted much of his time to speaking throughout the country on behalf of the medical profession. He has represented the American Medical Association at numerous con-

The 1965 Program Committee

Dr. Richard J. Stevens of Huntington is Chairman of the Program Committee for the 98th Annual Meeting of the West Virginia State Medical Association. Other members are Drs. Richard W. Corbitt of Parkersburg, Jack Leckie of Huntington, Kenneth G. MacDonald of Charleston and Maynard P. Pride and Clark K. Sleeth of Morgantown. They were appointed by the President, Dr. Albert C. Esposito of Huntington.

gressional hearings and has appeared in nationally televised debates with proponents of King-Anderson legislation.

The Program Committee has issued a cordial invitation to physicians, members of the Auxiliary and their families to hear the addresses by Drs. Appel, Judd and Annis.

Presidential Address

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will deliver his Presidential Address at the second session of the House of Delegates which will be held in Chesapeake Hall on Saturday afternoon, August 28, at two-thirty o'clock.

Pre-Convention Meetings

The convention will not be formally opened until Thursday morning, August 26; however, the pre-convention meeting of the Council will be held on Wednesday morning, August 25, and the first session of the House of Delegates will be held that afternoon.

The registration desk will be open on the main floor lobby from 8:30 A. M. to 5:00 P. M. daily during the convention.

General Scientific Sessions

The three general scientific sessions will be held in Governor's Hall in the West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies also will be held in Governor's Hall and the Mountaineer Room in the new Wing. Other meetings will be held in the Convention Unit.

The industrial and scientific exhibits will be housed in the beautiful and spacious Exhibit Center in the West Virginia Wing.

Motion Pictures

Dr. John J. Mahood of Bluefield is chairman of the committee arranging the motion picture program during the three-day meeting. Sound motion pictures on appropriate scientific subjects will be shown on Thursday, Friday and Saturday mornings prior to the opening of each general session. The films will be shown in Governor's Hall.

Formal Opening of Convention Thursday Morning

The convention will be called to order by Doctor Stevens on Thursday morning, August 26, at nine o'clock. The address of welcome will be delivered by Doctor Esposito and the first speaker on the program will be Doctor Judd.

The meeting will then be turned over to Dr. Richard W. Corbitt of Parkersburg, who will serve as moderator for the first general session. The guest speakers and their subjects are as follows:

R. Gordon Douglas, M. D., Emeritus Professor of Obstetrics and Gynecology, Cornell University Medical College, New York City; and Consultant in Obstetrics and Gynecology to the New York Hospital. Subject: "Amniocentesis and Intra-Uterine Transfusion in Rh Immunized Patients."

Thomas E. Shaffer, M. D., Professor of Pediatrics and Preventive Medicine, Ohio State University College of Medicine, Columbus; and Team Physician for Ohio State Athletic Teams. Subject: "The Adolescent Athlete."

Cornelius E. Sedgwick, M. D., Member of the General Surgery Staff, Lahey Clinic Foundation, Boston, Massachusetts. Subject: "Portal Hypertension."

Thursday Afternoon Program

Dr. Maynard P. Pride of Morgantown will preside at a meeting of the Resolutions Committee which will be held at two o'clock on Thursday afternoon.

Dr. Cornelius E. Sedgwick of Boston will present a paper on "Inflammatory Lesions of the Intestines" before a meeting of the Section on Surgery at two

Seigle W. Parks, M. D.
President Elect

Luncheon for Past Presidents

A luncheon honoring past presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 26, during the 98th Annual Meeting.

Dr. Charles L. Goodhand of Parkersburg, immediate past president, will preside. Twenty-four past presidents have been invited to attend the luncheon.

Edward R. Annis, M. D.

o'clock. Dr. William E. Gilmore of Parkersburg will preside.

Dr. Claude A. Frazier of Asheville, North Carolina, and Dr. Nathan Schaffer of East Orange, New Jersey, will appear as speakers before an open meeting of the West Virginia State Society of Allergy at two o'clock.

Doctor Frazier will present a paper on "Insect Sting Allergy and Its Management," and the subject of Doctor Schaffer's paper will be "Modern Assessment of Therapy for Allergy Diseases—1965."

MCV Alumni Party

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a cocktail party on Thursday evening at six-thirty o'clock. Dr. Lee B. Todd of Quinwood is in charge of arrangements.

Second General Session
Friday Morning

Dr. Jack Leckie of Huntington will serve as moderator for the second general scientific session beginning at nine o'clock on Friday morning, August 27. The guest speakers and their subjects are as follows:

William G. Thurman, M. D., Professor and Chairman of Pediatrics, University of Virginia School of Medicine, Charlottesville. Subject: "What to Do With the Bleeding Child."

Samuel D. McPherson, Jr., M. D., Clinical Professor of Ophthalmology and Acting Chief of the Division of Ophthalmology, University of North Carolina School of Medicine. Subject: "Some Ocular Signs of Systemic Disease."

Leon Schiff, M. D., Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Subject: "The Differential Diagnosis of Jaundice."

Clinical Pathological Conference

One of the features of the scientific program will be a clinical pathological conference which will be held on Friday morning, following formal presentations by three guest speakers. Dr. Kenneth G. MacDonald of Charleston will serve as moderator.

Dr. Leon Schiff of Cincinnati will serve as the clinical discussant and the pathologic and radiographic findings will be presented by Drs. Grover B. Swoyer and J. Dennis Kugel of Charleston, respectively.

A protocol for the CPC was inserted in a Convention Bulletin mailed to all members of the State Medical Association in July. Additional copies will be available for distribution during the meeting.

Friday Afternoon Program

Dr. Leon Schiff of Cincinnati will present a paper on "The Use of Steroids in Liver Disease" before a meeting of the Section on Internal Medicine at two o'clock. Dr. Arnold J. Brody of White Sulphur Springs will preside and a business meeting will follow the scientific program.

Dr. A. B. Curry Ellison of Charleston will preside at a business meeting of the West Virginia Chapter

Convention Timetable

General scientific sessions daily beginning at 9:00 o'clock on Thursday, Friday and Saturday.

House of Delegates: First session, Wednesday afternoon at 3 o'clock and second session, Saturday afternoon at 2:30 o'clock.

Scientific and Industrial Exhibits (Exhibit Center): Open from 8:30 A. M. until 3:30 P. M. on Thursday and Friday, August 26 and 27; and from 8:30 A. M. to 1:00 P. M. on Saturday, August 28.

House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at The Greenbrier will be convened at 3:00 o'clock on Wednesday afternoon, August 25. In past years the first session was held on Wednesday evening.

The starting time also has been changed for the second session of the House of Delegates on Saturday afternoon, August 28. The session will be held at 2:30 o'clock rather than 3:00 o'clock in the past.

of the American Society of Internal Medicine which will be held immediately following the scientific and business sessions of the Section on Internal Medicine.

Drs. William G. Thurman of Charlottesville and Thomas E. Shaffer of Columbus will present papers before a meeting of the West Virginia Pediatric Society at two o'clock.

Doctor Thurman will discuss "Recent Advances in the Management of Malignant Disease," and the subject of Doctor Shaffer's paper will be "The Adolescent in Your Pediatric Practice."

Dr. Dwight P. Cruikshank of Parkersburg will preside at a meeting of the West Virginia Obstetrical and Gynecological Society which will be held at two o'clock. Dr. R. Gordon Douglas of New York City will present a paper on "Breech Presentation."

Doctor McPherson will present a paper on "The Surgical Treatment of Chronic Open Angle Glaucoma" before a meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at two o'clock. Dr. R. Alan Fawcett of Wheeling will preside.

Dr. Benjamin W. Drompp, Professor and Head of the Division of Orthopedic Surgery at the University of Arkansas Medical Center, will present a paper on "Current Concepts in the Surgery of Rheumatoid Arthritis" before the Section on Orthopedic Surgery at two o'clock. Dr. Robert S. Wilson of Clarksburg will preside.

Dr. Carrel M. Caudill of Charleston will preside at a meeting of the Section on Neurology, Neurosurgery and Psychiatry at two o'clock. There will be a panel discussion on "Management Problems in Head Injuries" and the speakers will be Drs. Charles E. Goshen and George R. Nugent, members of the faculty at the West Virginia University School of Medicine.

The following sections and societies have scheduled business meetings for two o'clock: Section on Urology, the West Virginia Radiological Society and the West Virginia Society of Anesthesiologists.

Dr. L. J. Pace of Princeton will preside at a meeting of the Committee on Nominations which will be held at five o'clock.

Third General Session
Saturday Morning

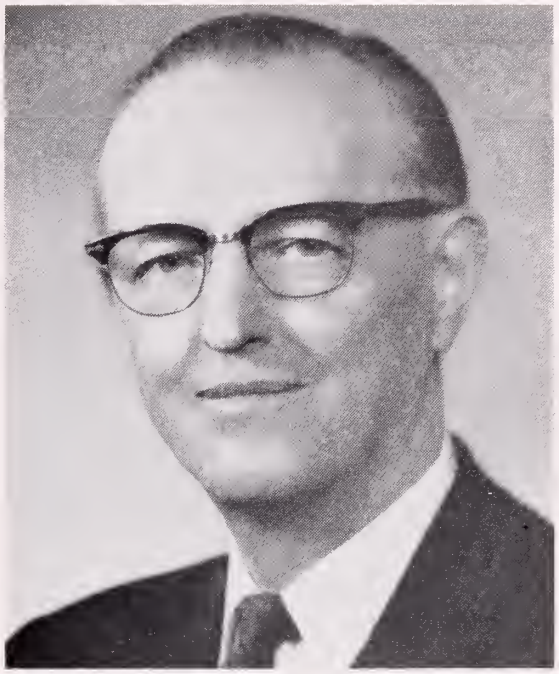
Dr. Clark K. Sleeth of Morgantown will serve as moderator at the third and final scientific session beginning at nine o'clock on Saturday morning, August 28.

Six members of the faculty of the West Virginia University School of Medicine will present a Symposium on "Emergency Maintenance of Life." The speakers and their subjects are as follows:

N. W. B. Craythorne, M. D., Associate Professor and Chairman of the Division of Anesthesiology (Introductory Remarks).

Paul E. Huffington, M. D., Instructor in the Division of Anesthesiology. Subject: "Maintenance of the Airway."

Allen E. Yeakel, M. D., Associate Professor of Anesthesiology. Subject: "Respiratory Resuscitation."



Walter H. Judd, M. D.

Herbert E. Warden, M. D., Professor of Surgery. Subject: "Cardiovascular Resuscitation."

N. W. B. Craythorne, M. D. Subject: "The Pharmacological Aspects of Cardiac Arrest."

Alphonse C. Edmundowicz, M. D., Assistant Professor of Medicine. Subject: "Electrical Defibrillation of the Heart."

Bernard Zimmermann, M. D., Professor and Chairman of the Department of Surgery. Subject: "The Management of Crushed Chest."

Alphonse C. Edmundowicz, M. D. Subject: "The Management of Life-Threatening Arrhythmias."

There will be a 30-minute question and answer period following the presentation of formal papers.

Saturday Afternoon Meetings

Only one section meeting has been scheduled for Saturday afternoon. Dr. Grover B. Swoyer will pre-

Motion Picture Schedule

Dr. John J. Mahood of Bluefield, chairman of the motion picture program for the annual meeting at The Greenbrier, has announced that two films will be shown in Governor's Hall each morning prior to the general scientific sessions.

The films on Thursday will be "Alcoholism" and "Fetal and Neonatal Circulation." On Friday morning, the films will be "Portal Decompression" and "Normal and Abnormal Platelets."

The films on Saturday morning will be "Resuscitation for Cardiac Arrest" and "Hyperbaric Oxygenation."

side at a business meeting of the West Virginia Association of Pathologists which will be held at one-thirty o'clock.

Second Session of the House of Delegates

Doctor Esposito will preside at the second and final session of the House of Delegates which will be convened at two-thirty o'clock on Saturday afternoon.

Doctor Esposito will deliver his Presidential Address at this session of the House.

Dr. Seigle W. Parks of Charleston, the President Elect, will be installed as President as the last order of business at this session. Other officers for 1965-66 also will be elected and installed.

Creel S. Cornwell, Jr., of Lost Creek, and William L. Mossburg of Morgantown, the recipients of the State Medical Association's 1965 four-year scholarships to the West Virginia University School of Medicine, will be introduced at this session.

Dance on Friday Evening

The Woman's Auxiliary to the West Virginia State Medical Association will sponsor a cabaret dance in Chesapeake Hall on Friday evening, August 27, beginning at ten o'clock. Music will be furnished by "The Townsmen."

Cocktail Party on Saturday Evening

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening, August 28, from six-thirty to seven-thirty o'clock. All members of the Association and the Auxiliary, their families, representatives of the industrial and scientific exhibits and guests are invited to attend.

Prizes to the winners of the golf tournament will be awarded at the cocktail party.

Industrial and Scientific Exhibits

Physicians, members of the Auxiliary and guests are invited to visit the more than 50 informative industrial and scientific exhibits which will be housed in the Exhibit Center throughout the meeting. The exhibits will be open daily from 8:30 A. M. to 3:30 P. M.

Heavy Registration

The number of reservations for rooms at The Greenbrier during the Annual Meeting has passed the 450 mark. It is anticipated that more than seven hundred persons will be in attendance.

Pediatric Meeting in Chicago

The 34th annual meeting of the American Academy of Pediatrics will be held at the Palmer House in Chicago, Oct. 23-28.

About 3,000 pediatricians are expected to attend the seminars, round table discussions, general sessions, film program and scientific and technical exhibits.

The preliminary program, housing and registration forms may be obtained by writing to the Academy at 1801 Hinman Avenue, Evanston, Illinois 60204.

Doctor Holroyd Reelected Secretary Of Aces and Deuces

Dr. Frank J. Holroyd of Princeton was reelected to a seventh consecutive term as secretary-treasurer of the Aces and Deuces organization at the annual breakfast meeting held at the Americana Hotel in New York City on June 22. The meeting was attended by more than 175 persons.

Dr. James M. Kolb of Clarksville, Arkansas, was elected president, succeeding Dr. Lindsay E. Beaton of Tucson, Arizona.

The Aces and Deuces is a social organization composed of AMA delegates and alternates from state medical associations which have one or two members in the House of Delegates.

An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the Clinical Convention in Philadelphia.

Two West Virginia Physicians Elected to College Board

Two physicians, both native West Virginians, have been elected to the Board of Governors of Alderson-Broaddus College in Philippi.

They are Dr. Frank V. Langfitt of Clarksburg, a past president of the State Medical Association, and Dr. Waitman Zinn, who now resides in Fort Lauderdale, Florida.

Doctor Langfitt serves as Vice President of the Union Protestant Hospital Board and also is a Director of the Union National Bank in Clarksburg.

Doctor Zinn is a former Professor of Otolaryngology at the University of Maryland and Professor of Bronchoscopy at Georgetown University in Washington.

The Board of Governors serves the college in an advisory capacity in addition to the Board of Trustees.

Relocations

Dr. Sidney Auerbach, formerly of Huntington, has accepted appointment as co-director of laboratories at the St. Paul-Ramsey Hospital and also is serving as Instructor in Clinical and Anatomical Pathology at the University of Minnesota College of Medicine.

* * * *

Dr. Andrew J. Kapcar, who has been serving for the past three years as associate pathologist at Memorial Hospital in Charleston, assumed his duties as director of laboratories at the Northern Hospital of Surry County in Mt. Airy, North Carolina, on July 1.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28, 1965.

Dr. Joseph T. Mallamo of Fairmont Defending Golf Champion

Dr. Joseph T. Mallamo of Fairmont will attempt to retire the championship trophy when he defends his title in the Medical Golf Tournament which will be held in connection with the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Doctor Mallamo shot a 71 in 1964 to win his seventh title and a second leg on the beautiful trophy offered by the Hospital and Physicians Supply Company of Charleston. The physician who wins the tournament three times wins permanent possession of the trophy. Doctor Mallamo retired a previous trophy in 1960.

Dr. R. R. Brown of Romney, who won the tournament in 1963, finished one stroke behind Doctor Mallamo last year with a 72.

Other low gross scorers were Drs. Joseph A. Smith of Dunbar, 76; Joseph H. Selman of Charleston, 77; and Jack Leckie of Huntington, William C. Morgan, Jr., of Charleston and George A. Curry of Morgantown, 80.

Dr. Joseph A. Smith of Dunbar, Chairman of the Golf Committee said that physicians participating in the tournament will pay an entrance fee of $5 payable at the time they register to play in the tournament. There will be several prizes in addition to the championship trophy.

Physicians may engage in tournament play both mornings and afternoons during the three-day meeting. Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by four o'clock on Saturday afternoon, August 28.

American Heart Association Meeting In Bal Harbour, Florida

Six programs on clinical cardiology and simultaneous sessions on specialized cardiovascular subjects have been planned in connection with the 38th Annual Scientific Session of the American Heart Association which will be held at the Americana Hotel in Bal Harbour, Florida, October 15-17.

The clinical sessions, consisting of panels, symposia, lectures and papers reporting clinical investigations, are designed as a postgraduate course in cardiology. Concurrent sessions will be devoted to the presentation of papers on original work in various cardiovascular sub-specialties.

One of the features of the meeting will be a one-day session on "stroke" which will emphasize the presentation of original investigative work in the cerebrovascular field.

Registration forms, which include applications for hotel reservations, may be obtained from the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Nominating Committee To Meet On Friday, August 27

The Committee on Nominations of the State Medical Association will meet at five o'clock on Friday afternoon, August 27, during the Annual Meeting at The Greenbrier.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, its nominee for the offices of President Elect, Vice President, Treasurer, and the American Medical Association Delegate and Alternate.

The current councilor-at-large, Dr. L. J. Pace of Princeton, will serve as chairman and the other members are the following senior councilors in point of service from each councilor district: Drs. Joseph L. Curry of Wheeling, Maynard P. Pride of Morgantown, John E. Echols of Richwood, I. Ewen Taylor of Huntington, Buford W. McNeer of Hinton, and William B. Rossman of Charleston.

The By-Laws also specify that nominations may be made from the floor for the above mentioned officers.

Third Annual ACP Fall Meeting In Miami Beach, Oct. 7-9

The third annual fall meeting of the American College of Physicians will be held at the Deauville Hotel in Miami Beach, Florida, October 7-9.

The three-day program will feature three major lectures, 28 clinical papers, 27 presentations on basic science and clinical investigations and four symposia on problems of importance to practicing physicians.

Further information may be obtained by writing the American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Charleston Hospital Honors Residents and Interns

Dr. Frank Medford of Butner, North Carolina, retiring Chief Resident in Medicine at Charleston Memorial Hospital, was awarded a $200 prize for a scientific paper recently.

Doctor Medford presented a paper on "Cardiac Arrest in the Community Hospital."

The award was made in conjunction with the Hospital's Education Day program on June 25.

Two interns—Drs. Thomas Dotson of Summersville and Spencer Lee Bivens of Charleston—were awarded $100 each for their papers.

Doctor Dotson investigated a rare type of pneumonia that took the life of an infant at the hospital, and Doctor Bivens studied a rare disease affecting pregnant women.

Dr C. A. Hoffman Elected Member Of Key AMA Committee

Dr. C. A. Hoffman of Huntington was elected to membership on a key committee of the American Medical Association during the 114th Annual Convention, which was held in New York City, June 20-24.

C. A. Hoffman, M. D.

Doctor Hoffman, a Past President of the West Virginia State Medical Association, was elected to a five-year term on the nine-member AMA Council on Medical Service. The House of Delegates elected Doctor Hoffman on the first ballot in a contest in which two other physicians were candidates.

The activities of the Council include investigating matters pertaining to the economic and social aspects of medical care and informing state and local medical societies of proposed changes affecting medical care in the nation.

Doctor Hoffman has been serving as a member of the Committee on Insurance and Pre-Payment Plans, a standing committee of the Council on Medical Service. He also has served since 1958 as one of West Virginia's two Delegates to the AMA.

Earlier this year Doctor Hoffman was honored by being elected to the Executive Committee of the Board of Directors of the National Association of Blue Shield Plans.

Doctor Hudson Named President Elect

Dr. Charles L. Hudson of Cleveland, who has served as a member of the AMA Board of Trustees since 1961, was named President Elect at the concluding session of the House of Delegates on June 24. He will take office as President in June, 1966, succeeding Dr. James Z. Appel of Lancaster, Pennsylvania, who was installed as President during the New York meeting.

Dr. W. Andrew Bunten of Cheyenne, Wyoming, was elected Vice President, and Drs. Milford O. Rouse of Dallas and Walter C. Bornemeier of Chicago were reelected Speaker and Vice Speaker of the House of Delegates, respectively.

Dr. Irvin E. Hendryson of Denver was elected to the Board of Trustees to fill the unexpired term of Doctor Hudson. Reelected to the Board were Drs. Lester D. Bibler of Indianapolis, J. B. Copeland of Austin, Texas, Gerald D. Dorman of New York City, and L. O. Simenstad of Osceola, Wisconsin.

Dr. Russell B. Roth of Erie, Pennsylvania, was reelected a member of the Council on Medical Service, and Dr. James H. Berge of Seattle was named to succeed himself on the Judiciary Council.

Named to the Council on Medical Education were Drs. Bland W. Cannon of Memphis, William R. Willard of Lexington, Kentucky, and Earle M. Chapman of Boston. Dr. George D. Johnson of Spartanburg, South Carolina, was reelected a member of the Council on Constitution and By-Laws.

State Physicians Attend Meeting

In addition to Doctor Hoffman, the meeting was attended by the other AMA Delegate, Dr. Frank J. Holroyd of Princeton.

Also attending the meeting were the following officers of the State Association: Drs. D. E. Greeneltch of Wheeling and Thomas G. Reed of Charleston, Alternate Delegates; Dr. Albert C. Esposito of Huntington, President; Dr. Seigle W. Parks of Charleston, President Elect; and Dr. Charles L. Goodhand of Parkersburg, Chairman of the Council.

Summary of the New York Meeting

The following summary of the New York meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

Federal health care legislation, the report of the President's Commission on Heart Disease, Cancer and Stroke, the Gundersen Committee report on organization of the House of Delegates and a plan for a new method of establishing AMA scientific sections were among the major subjects acted upon by the House of Delegates.

The 1965 AMA Distinguished Service Award was won by Dr. Tinsley R. Harrison of Birmingham, Alabama, for his outstanding work in the field of cardiovascular diseases.

Final registration figures reached a grand total of 64,517, including 24,268 physicians, the largest physician registration in the Association's history.

Health Care Legislation

Most controversial issue before the House was that of non-participation under any so-called "Medicare" law that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Doctor Appel's inaugural address.

The House recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In adopting a substitute resolution, the House declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country.

"When the fate of the pending medicare legislation is determined, this House will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary.

"In keeping with the testimony before your Committee, and the expressed policies of this House, this

action should in *no way* be interpreted as a change in Section 6 of the "Principles of Ethics" of the American Medical Association which plainly states: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care"; and that this House of Delegates reaffirm the principles of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its special meeting on February 7, 1965, and amended to read as follows:

'(1) No person needing health care shall be denied such care because of the inability to pay for it.

'(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

'(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.

'(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

'(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

'(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

'(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

'(8) Any such health care programs should provide funds only, and not direct services.

'(9) Funds for such programs may come from general tax revenues and not from social security taxes.'"

Offer to President Johnson

In a related action, urging that government seek the advice of the medical profession on health legislation, the House adopted a resolution which included the following statements:

"This House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.

"The American Medical Association make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

The DeBakey Commission Report

In considering seven resolutions involving the report and recommendations of the President's Commission on Health Disease, Cancer and Stroke, the House adopted a substitute statement which resolved that:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular Commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical medical research, education and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the Board, its councils, and the Association members."

Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance, and proper use of cancer registries in hospitals, but that the establish-

ment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology and physical medicine in hospitals.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions, or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the Board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the Board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the Board for study a resolution calling for "a program of purchase of health insurance . . . in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the Board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

House received a series of resolutions urging approval of an American Board of Family Practice. All were referred to the Council on Medical Education.

Urged the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

Encouraged state and county medical societies to participate in the formation of State Associations of the Professions, "to provide a vehicle, for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit."

Amended the bylaws to provide that the Vice President shall succeed to the presidency should the President die, resign or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

Opening Session

Doctor Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of personal opinion, "we do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." Outgoing President Donovan F. Ward pointed out:

"If it were true that the public climate was the dominant factor affecting the decisions of those who make legislative history, we now would be winning both in the House and the Senate."

Health Care in Scandinavia Described in Magazine

The May 1965 issue of *Scandinavian Times* gives a description of health care in Sweden, Denmark, Norway and Finland. Health insurance is compulsory in all these countries but the system is different in its application in each county. To any student interested in the political philosophy of State Medicine, the article makes very instructive and interesting reading.

Mr. A. John Harrison, SAS Building, 138-02 Queens Boulevard at Van Wyck Expressway, Jamaica, New York, states he will be pleased to handle arrangements for any traveling physician who wishes to see the latest developments in medicine and health in Scandinavia.

Suicide Symposium in Washington

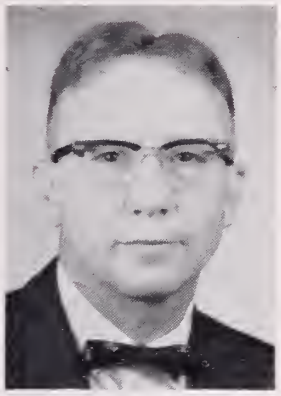
The George Washington University School of Medicine will conduct a symposium on suicide at the Lisner Auditorium in Washington, D. C., on October 14.

The one-day program will explore the various facets of suicide, including suicide's cultural role, social causation, statistical importance, psychodynamics, treatment and prevention.

Further information may be obtained by writing to Dr. Leon Yochelson, George Washington University Hospital, Department of Psychiatry, 901 23rd Street, N. W., Washington, D. C. 20037.

Dr. Ralph W. Ryan of Morgantown Co-Author of New Book

Dr. Ralph W. Ryan of Morgantown is the co-author of a new book, "Industrial and Traumatic Ophthalmology," which was published recently by the C. V. Mosby Company of St. Louis.



Ralph W. Ryan, M. D.

The book is a symposium on all aspects of industrial opththalmology and covers such subjects as fitting the eyes to the job; plant lighting; the ophthalmology of driving; emergency care and medical and surgical treatment of industrial eye injuries, whether chemical radiation, thermal or mechanical; and the pathology and sequellae of ocular trauma.

Doctor Ryan gained interest in industrial ophthalmology at the University of Michigan where he spent a year doing research and writing a thesis in this field for his Master of Science degree in Ophthalmology.

He has served on the Sub-Committee on Industrial Ophthalmology of the American Medical Association, the Industrial Advisory Committee of the National Society for the Prevention of Blindness, and the Committee on Industrial Ophthalmology of the National Medical Foundation for Eye Care.

New Association Members

Dr. Francis J. Januszeski, Union Protestant Hospital, Clarksburg (Harrison). A native of Baltimore, Doctor Januszeski was graduated from the University of Maryland with a B.S. degree in Pharmacy. He also received his M.D. degree in 1938 from the University of Maryland School of Medicine, and he served an internship at Maryland General Hospital in Baltimore, 1938-39. He is a Diplomate of the American Board of Pathology and was previously located in Allentown, Pennsylvania.

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Dr. R. James Yates, 197 Booth Avenue, Beckley (Raleigh). Doctor Yates, a native of Blackey, Virginia, was graduated from Emory and Henry College and received his M.D. degree in 1959 from the Medical College of Virginia. He interned and served residencies at Richmond Memorial Hospital and Beckley Memorial Hospital, 1960-64. His specialty is internal medicine.

Doctor Bishop Named to VA Post

Dr. Charles J. Bishop has been appointed director of the Veterans Administration Hospital in Huntington.

Doctor Bishop served at the VA Center in Martinsburg from April 1957 to April 1960, when he was named director of a VA installation in Amarillo, Texas.

More Than 60 Attend 16th Annual B-R-T Postgraduate Session

More than 60 members and guests attended the 16th Annual Postgraduate meeting of the Barbour-Randolph-Tucker Medical Society which was held at the Elks Country Club near Elkins on Thursday, June 17.

Dr. Arch C. Thompson of Elkins served as moderator for the program. The speakers and their subjects were as follows:

Jack M. Harrison, M. D., Associate Professor of Surgery, Medical College of Virginia, "Evaluation of the Thyroid Nodule by Use of the Radioactive Iodine Scintogram."

Richard H. Kirkland, M. D., Associate Professor of Medicine, Medical College of Virginia, "Physiologic Basis of Thyroid Function Tests."

William E. Laupus, M. D., Chairman, Department of Pediatrics, Medical College of Virginia, "Pediatric Emergencies."

James E. Clark, M. D., Assistant Professor of Clinical Medicine and Director of the Artificial Kidney Unit, the Jefferson Medical College of Philadelphia, "Isolated Small Intestinal Loop Dialysis in the Management of Chronic Renal Failure."

Congressman Arch A. Moore, Jr., of Glen Dale was principal speaker at a banquet that evening. He spoke on "The Role of the Federal Government in the Practice of Medicine."

Congressman Moore stated that the Federal Government should be responsible in some measure for the care of the indigent, in supplementing funds for the building of hospitals and development of health facilities in the communities which cannot afford these facilities, and for control of contagious disease, air pollution and water contamination.

Dr. Joseph T. Mallamo of Fairmont won the golf tournament which was held in connection with the one-day meeting.

PG Course on Radioactive Scanning In Pittsburgh, Oct. 21-22

A postgraduate course on "Advances in Radioactive Scanning" will be sponsored by the University of Pittsburgh School of Medicine at the Penn Sheraton Hotel in Pittsburgh, October 21-22.

The director of the course is Dr. Yen Wang, associate professor of radiology at the Presbyterian-University Hospital, University of Pittsburgh. The guest faculty will discuss current methods of dynamic scanning and their clinical application and ample time will be set aside for informal discussion and consultation. Special emphasis will be placed on rapid scintillation scanning, the use of the scintillation camera and image scanning.

Further information may be obtained by writing to Dr. Campbell Moses, Director of Postgraduate Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania 15213.

Critical Polio Eradication Period Is Predicted

Although West Virginia has experienced an unprecedented period of freedom from polio, there are various indications that the next several months could represent a critical period in attempting to eradicate the disease.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health," noted that projections from a recent survey in 29 of the state's counties revealed that only slightly more than 50 per cent of the population has received either Salk or Sabin vaccine. This figure is far below a minimum immunity level of 70 to 75 per cent considered by most epidemiologists as necessary to break the chain of infection.

He also pointed out that since the survey thousands of new babies have been born in the state who have not had vaccine, adding significant numbers to the under-5 age group which was shown to have the least protection during the sample survey.

Since polio is a cyclical disease and the summer months are traditionally a period when cases hit a peak, this factor cannot be discounted although there is no evidence to indicate an outbreak is imminent.

In another issue, Doctor Dyer discussed changes which will result from implementation of the recently adopted 1964 food code, designed to extend high sanitation standards to all areas of food preparation and service.

He noted that the new regulation is a move to keep pace with the change in America's eating habits and to apply new knowledge and advanced technology in food sanitation. Whereas the 1950 code placed emphasis on the esthetic consideration of a food service establishment, the new code stresses those items which insure the quality of the food itself, the personnel employed and the manner in which food is processed, stored and served.

One notable change in the new food code, he indicated, is a provision for temporary food service establishments which now must comply with all provisions of the new code which are applicable to their operation. In the past, only limited specifications were included for church, civic, service or social organizations which served food to the public.

Doctor Dyer pointed out that this section of the food code may well help reduce the number of foodborne illness outbreaks since mass food poisoning is often credited to affairs where food is prepared and served by inexperienced and untrained persons.

In 1959 and 1960, Public Health Reports show that 5,362 cases of food poisoning resulted from private clubs, social gatherings and picnics. During the same period only 2,027 cases of foodborne diseases were reported from public eating establishments.

Another change in the code, he indicated, is that no home canned goods are permitted to be served. Of 24 cases of botulism food intoxication and seven fatalities reported in 1959 and 1960, all resulted from home canned goods. In addition, one death in the state in 1963 was attributed to home canned food.

Annual Cabell County Symposium In Huntington on Sept. 9

The Cabell County Medical Society's 11th Annual Symposium on "Arthritis" will be held at the Frederick Hotel in Huntington on Thursday, September 9.

Dr. Thomas F. Scott, the Program Chairman, announced the registration desk would open at 8:00 A. M. and that the Scientific Session would begin promptly at 9:00 A. M. There will be no registration fee and additional information may be obtained by writing Doctor Scott, 1139 Fourth Avenue, Huntington, West Virginia. Speakers participating in the program will be as follows:

Rolla D. Campbell, Jr., M. D., New York City, Associate Professor of Orthopedic Surgery, Cornell University Medical College.

Barry Decker, M. D., Richmond, Virginia, Director of Medical Education, Richmond Memorial Hospital.

J. D. O'Duffy, M. D., Cleveland, Ohio, Department of Rheumatic Diseases, The Cleveland Clinic.

William H. Kammerer, M. D., New York City, Clinical Associate Professor of Medicine, Cornell University Medical College.

John Soshea, M. D., St. Petersburg, Florida.

Further information concerning the symposium will be published in the September issue of *The Journal.*

Dr. Thomas L. Thomas Named School Medical Director

The Ohio County Board of Education has appointed Dr. Thomas L. Thomas of Wheeling as public school medical director, effective in September.

Doctor Thomas said he will quit private practice for full-time work in the field of public health. He has been city-county health officer since 1955 and he expects to continue in that post and combine it with the public school position.

New ACCP Officers

Dr. Oliver K. Neiss, a retired major general and former Surgeon General of the Medical Corps of the U. S. Air Force, was installed as President of the American College of Chest Physicians during the 31st annual meeting in New York City, June 17-21.

He succeeds Dr. Alfred Goldman of St. Louis. Dr. Howell S. Randolph of Phoenix, Arizona, was named president elect, and Dr. Arthur M. Olsen of Rochester, Minnesota, was reelected chairman of the Board of Regents.

18 Hours AAGP Credit

The 98th Annual Meeting of the West Virginia State Medical Association has been authorized as acceptable for 18 hours credit by the American Academy of General Practice.

House of Delegates To Consider Kanawha County Resolution

The following resolution, adopted by the Kanawha Medical Society at a meeting held in Charleston on June 8, has been submitted to the House of Delegates for consideration during the Annual Meeting at The Greenbrier later this month:

SUBJECT: Third Party Review Committee.

BE IT RESOLVED, That there shall be elected two members from each councilor district to serve on a Third Party Review Committee who shall have as their responsibility the review of all third party insurance programs having service policies and make recommendations in regard to the coverage of such policies, the maximum annual income of the individuals and families covered under such service policies, and the fees for service rendered to these recipients, and

BE IT FURTHER RESOLVED, That such recommendations are to be presented to the House of Delegates of the West Virginia State Medical Association at each annual meeting for its consideration, ratification or alteration, and

BE IT FURTHER RESOLVED, That all other policies not conforming to these recommendations to be considered as an indemnity program in their coverage of physicians' services whether of a vendor system type or a direct recipient payment program, and

BE IT FURTHER RESOLVED, That no decision at the State level on service or indemnity programs will be binding until after properly ratified on the floor of local county medical societies.

PG Course In GP Problems

A postgraduate course in "Common Problems in General Practice-Office Procedures" will be conducted in St. Petersburg, Florida, October 29-30.

The Mound Park Hospital Foundation of St. Petersburg is sponsoring the course in cooperation with the Florida Academy of General Practice. Registration will be October 28.

The American Academy of General Practice has approved the course for 14 accredited hours. The teaching faculty will be composed of selected guest lecturers and qualified Florida participants.

Further information may be obtained by writing to Dr. M. A. Barton, President of the Mound Park Foundation.

Products of Research That Save Lives

Let the law deal harshly with any dishonesty, false claims or unsafe practices found in the drug industry, but let us not encourage unlimited power by the FDA which could destroy the tree laden with the fruit of honest research because of one ailing branch.

We would suggest . . . a resolution of confidence in the pharmaceutical industry whose products have saved the lives of so many children. It is easy to forget that the life of President Lincoln's son could probably have been saved by antibiotics.—Robert F. Lorenzen, M. D., in Arizona Medicine.

80 Per Cent of All Americans Have Health Insurance

Nearly four out of five Americans have health insurance, and last year these insured persons received $8.7 billion in benefits. These were the key findings of the Health Insurance Council's 19th annual survey. The Council, in a recent report, said that at the end of 1964 more than 151 million persons had hospital expense insurance. Of these persons, 93 per cent also had surgical expense insurance and 72 per cent had regular medical (non-surgical) expense protection.

The Council survey on the extent of voluntary health insurance in the United States is based on reports from insurance companies, government agencies, Blue Cross, Blue Shield, and Medical Society plans.

The 151,123,000 persons with hospital insurance represent 79 per cent of the civilian population. The total is four million higher than in 1963 when, revised figures show, 147,168,000 persons (78 per cent) were protected.

Benefit payments in 1964 made by all insuring organizations for hospital, surgical and medical care totaled $7.7 billion, up $820 million over the 1963 total, the Council reported. In addition, persons with loss-of-income insurance received $1,012 million in benefits from insurance companies.

The grand total in health insurance benefits came to $8,697,000,000 for 1964, a record high, and an 11.5 per cent increase over the 1963 total of $7,801,000,000.

Council statistics show that growth in coverage and benefits has been considerable over the 1954-64 decade. Fifty million more persons were protected by health insurance at the end of 1964 than in 1954 when 101,493,000 persons were insured. Of this number, 84.6 per cent also had surgical insurance and 46.6 per cent had regular medical protection. Benefits in 1964 were nearly six billion dollars more than in 1954 when they totaled $2,720,000.000.

ACP, MCV Offer Course In Internal Medicine

The American College of Physicians has arranged a course on "Basic Mechanisms In Internal Medicine" in cooperation with the Medical College of Virginia. The course will be conducted in Richmond, September 20-24.

The purpose of the course is to present new and significant advances in internal medicine with emphasis on basic mechanisms and patho-physiological concepts as they relate to clinical manifestations and to therapy of disease.

Dr. W. T. Thompson will serve as director of the course. Co-directors are Drs. Charles M. Caravati and Kinloch Nelson.

Registration forms and additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

President of AMA Auxiliary To Attend Annual Meeting

Mrs. Richard A. Sutter of St. Louis, Missouri, President of the Woman's Auxiliary to the American Medical Association, will attend the 41st Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 26-28.

Mrs. Richard A. Sutter

Mrs. Jordan Kelling

Another honor guest will be Mrs. Jordan Kelling of Waverly, Missouri, President of the Woman's Auxiliary to the Southern Medical Association.

Mrs. George A. Curry of Morgantown, President of the State Auxiliary, will preside at the three-day meeting which will be held in conjunction with the 98th Annual Meeting of the West Virginia State Medical Association. More than 200 wives of physicians are expected to register.

Pre-Convention Meetings

Mrs. Curry will preside at a pre-convention meeting of the Executive Board which will be held at four o'clock on Wednesday afternoon, August 25, the day preceding the formal opening of the convention.

Members of the Auxiliary have been extended a cordial invitation to attend the first session of the Association's House of Delegates which will be held earlier that afternoon. Doctor James Z. Appel of Lancaster, Pennsylvania, President of the AMA will be the guest speaker.

Address by Dr. Walter H. Judd

Physicians, wives and their families are invited to hear an address by Dr. Walter H. Judd, former medical missionary and one of the country's foremost statesmen, at the Association's first general session in Governor's Hall at nine o'clock on Thursday morning, August 26.

Following the address by Doctor Judd, members of the Auxiliary will meet in the Fillmore and Van Buren rooms for the formal opening of the Auxiliary's convention.

First Business Session

The Auxiliary's general business sessions will be held on Thursday and Friday mornings, leaving the afternoons free for committee meetings and participation in the golf and bridge tournaments arranged in connection with the meeting.

Mrs. Curry will preside at the opening session on Thursday morning and the invocation and pledge of loyalty will be given by Mrs. J. C. Huffman, a past president.

The agenda at the first session will include reports of convention committees and recommendations of the Executive Board. Reports of the county auxiliary presidents also will be received, together with reports of the officers and the standing and special committees.

Keynote Address by Mrs. Sutter

The guest speaker at the first session will be Mrs. Richard A. Sutter, the AMA Auxiliary President, who will deliver the keynote address.

Mrs. Sutter has been active for many years in the Auxiliary and has served as president of her county and state auxiliaries. She has served as Chairman of the AMA Auxiliary Committee on Mental Health and was named President Elect of the AMA Auxiliary in 1964.

Mrs. Sutter also has been active in civic organizations and in 1961 she received a "Good Citizen" award from the St. Louis Globe-Democrat. She served as Chairman of the St. Louis County Health and Hospital Board and as Chairman of the Citizens' Committee which was successful in obtaining passage of an ordinance to flouridate the water supply of St. Louis County.

Mrs. Sutter is a native of St. Louis and was graduated from Washington University in that city. Her husband received his M. D. degree from Washington University School of Medicine and they have two daughters and one son, all whom have graduated from college.

Mrs. Curry and Mrs. Wilson P. Smith, the President Elect, will serve as hostesses at a luncheon on Thursday honoring the wives of presidents from neighboring state medical associations. A bridge party will be held that afternoon.

Address by Dr. Edward R. Annis

Auxiliary members and guests are cordially invited to hear an address by Dr. Edward R. Annis, a past president of the American Medical Association, at a meeting of WESPAC which will be held on Thursday night, beginning at 9:30 o'clock.

Election of Officers on Friday

Mrs. Pat A. Tuckwiller, immediate past president, will preside at the annual past presidents breakfast which will be held at eight o'clock on Friday morning.

Mrs. Curry will preside at the second general session which will be held at 9:30 A. M. on Friday. In addition to receiving reports of various committees, new officers will be elected for the coming year following a report of the nominating committee.

Mrs. Richard A. Sutter will install the newly elected officers. The presentation of the president's pin and gavel will be made by Mrs. George A. Curry to Mrs. Wilson P. Smith of Huntington, the incoming president. The presentation of the past president's pin to Mrs. Curry will be made by Mrs. Pat A. Tuckwiller.

Mrs. Wilson P. Smith, who will be installed as President, will deliver her inaugural address following the installation ceremonies.

Address by Mrs. Jordan Kelling

Mrs. Jordan Kelling, President of the Woman's Auxiliary to the Southern Medical Association, will be the guest speaker at the Friday morning session.

A past president of the Woman's Auxiliary to the Missouri State Medical Association, Mrs. Kelling is currently serving as Chairman of the Disaster Preparedness Committee of the Woman's Auxiliary to the American Medical Association. She is a member of the Board of Directors of Missouri Girls Town Foundation, a home for girls sponsored by the Missouri Federation of Women's Clubs.

The Kellings have one son, Captain George H. Kelling, MSC, USA, and two grandchildren.

Dr. Edward R. Annis also has accepted an invitation to speak at the second session, and will appear on the program immediately following Mrs. Kelling.

Friday Afternoon Program

Mrs. Buford W. McNeer of Hinton will preside at a luncheon for members-at-large which will be held on Friday.

A golf tournament has been arranged for Friday afternoon and auxiliary members are encouraged to visit the Exhibit Center which will be open until 3:30 o'clock on Thursday and Friday afternoons.

Cabaret Dance on Friday Night

The Woman's Auxiliary is in charge of the entertainment program for the convention and the feature will be a cabaret dance on Friday night in Chesapeake Hall.

Post-Convention Conference

Mrs. Wilson P. Smith, the incoming president, will preside at a post-convention conference and board meeting which will be held at 10:00 A. M. on Saturday, August 28. This meeting will be the final item of business on the formal program.

Second Session of House of Delegates

The second session of the Association's House of Delegates will be held at 2:30 o'clock on Saturday afternoon. Auxiliary members are cordially invited to attend both sessions of the House of Delegates.

The second session will feature the Presidential Address by Dr. Albert C. Esposito of Huntington. The two recipients of the State Medical Association's 1965 four-year scholarships to the West Virginia University School of Medicine also will be introduced. The final item of business will be the election and installation of new officers for the coming year.

A cocktail party and reception honoring the officers of the State Medical Association will be held on the Chesapeake Hall Terrace from 6:30 to 7:30 o'clock that evening. All members of the Auxiliary, State Medical Association, exhibitors, and guests are invited to attend.

Convention Committee

Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming, both of Morgantown, are co-chairmen of the convention. They were appointed by the President, Mrs. George A. Curry.

Mrs. George A. Curry
President

Mrs. Yaguda Named President Elect Of AMA Auxiliary

Mrs. George A. Curry of Morgantown, President of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. Wilson P. Smith of Huntington, the President Elect, were among West Virginians who attended the 42nd annual meeting of the Woman's Auxiliary to the American Medical Association in New York City, June 20-24.

Mrs. Asher Yaguda of Newark, New Jersey, was named president elect of the organization and will be installed as president during the 1966 meeting in Chicago. She will succeed Mrs. Richard A. Sutter of St. Louis, who was installed as president during the meeting in New York City.

Other new officers are as follows: Mrs. C. C. Long of Ozark, Arkansas, first vice president; Mesdames Robert F. Beckley of Lock Haven, Pennsylvania, Willard C. Scrivner of East St. Louis, Illinois, Erle E. Wilkinson of Nashville, Tennessee, and Clare W. Johnson of Phoenix, Arizona, all regional vice presidents; Mrs. Howard Liljestrand of Honolulu, Hawaii, treasurer; and Mrs. E. R. W. Fox of Coeur d'Alene, Idaho, constitutional secretary.

Mrs. Long, the new first vice president, served for several years as chairman of the Auxiliary's Rural Health Committee. She attended a recent Rural Health Conference at Jackson's Mill and she is well known to many physicians and their wives in West Virginia.

Drs. Greeneltch, Hoffman and Reed Named Members of MLB

Three past presidents of the West Virginia State Medical Association have been appointed by Gov. Hulett C. Smith to serve as members of the Medical Licensing Board of West Virginia. They are:

Dr. D. E. Greeneltch of Wheeling, who was reappointed for a five-year term ending June 30, 1970. He has served as a member of the Board since 1963.

Dr. Thomas G. Reed of Charleston, for a term ending June 30, 1970.

Dr. C. A. Hoffman of Huntington, for a term ending June 30, 1968.

Dr. D. A. MacGregor of Wheeling, a past president of the State Medical Association, also was reappointed by Governor Smith as a member of the West Virginia Board of Health for a nine-year term ending June 30, 1974.

Drs. Albert C. Esposito of Huntington, President of the State Medical Association, and L. J. Pace of Princeton, a past president, were appointed members of the State Board of Examiners for Practical Nurses. Doctor Esposito was appointed for a term ending June 30, 1968, and Doctor Pace will serve until June 30, 1970.

Another state physician, Dr. E. E. Hutton, Jr., of Elkins, was reappointed a member of the West Virginia Historic Commission for a term ending May 31, 1969.

The following physicians were reappointed to serve as superintendents of State hospitals and sanitariums:

Dr. Jorge Ribeiro, Welch Emergency Hospital; Dr. Phillip Johnson, Fairmont Emergency Hospital; Dr. Hugh S. Edwards, Pinecrest Sanitarium; Dr. Hilton D. Rocha, Hopemont State Hospital and Dr. George H. Guy, Andrew S. Rowan Memorial Home.

'Negative Placebo Responses'?

We observe that medicinals have an effect regardless of the composition of the substance contained within them. And further, we know that the placebo effect is not always favorable in terms of therapeutic response.

It is my conviction, as I have suggested earlier, that many of the "side effects" ascribed to various medications are, in fact, what can be called "negative placebo responses." It is not at all rare, for example, to observe adverse reactions following the administration of drugs—reactions which have nothing whatsoever to do with the pharmacological properties of the drug, but very much to do with the psychological factors which neither patient nor doctor nor nurse are very aware.

One of the most amazing events in medical practice is to observe a "side effect" from nothing more potent than a sterile hypo, or even from nothing more pharmacological than a venipuncture.—Gordon R. Forrer, M. D., in Michigan Medicine.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1965

Aug. 26-28—W. Va. State Medical Assn., The Greenbrier, White Sulphur Springs.
Aug. 30-Sept. 2—American Hosp. Assn., San Francisco.
Sept. 9—Cabell County Symposium, Huntington.
Sept. 9-11—American Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 10—Maryland Medical Society, Ocean City.
Sept. 11—W. Va. Heart Assn., Blackwater Falls State Park.
Sept. 16—W. Va. TB & Health Assn., Huntington.
Sept. 18-26—Pennsylvania Medical Soc., Atlantic City, N. J.
Sept. 19-25—World Medical Assembly, London.
Sept. 21-23—Kentucky Medical Assn., Louisville.
Sept. 23-25—W. Va. Hospital Assn., White Sulphur Springs.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 1-2—W. Va. Chapter, ACS, Morgantown.
Oct. 7-9—ACP, Miami Beach.
Oct. 8-10—W. Va. Div., Am. Cancer Soc., Wheeling.
Oct. 10-13—Medical Soc. of Virginia, Richmond.
Oct. 15-19—American Heart Assn., Bal Harbour, Fla.
Oct. 15-22—Col. of American Pathologists, Chicago.
Oct. 18-22—ACS Clinical Cong., Atlantic City.
Oct. 23-27—Am. Soc. of Anesthesiologists, Denver.
Oct. 23-28—Am. Acad. of Ped., Chicago.
Oct. 24-27—Am. Col. of Gastroenterology, Bal Harbour, Fla.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical Assn., Houston.
Nov. 14-19—American Acad. of Oph. & Otol., Chicago.
Nov. 27-28—ACCP, Philadelphia.
Nov. 27-Dec. 3—Radiological Soc. of N. America, Chicago.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Feb. 1-5—Am. Col. of Radiology, Chicago.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
April 25-28—Industrial Med. Assn., Detroit.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.

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Each capsule contains:

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Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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CONVENTION PROGRAM

98th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 26-28, 1965

WEDNESDAY MORNING

August 25

(Eastern Daylight Time)

9:00-5:00—Registration, Main Floor Lobby.

10:00—Pre-Convention Meeting of the Council. Charles L. Goodhand, M. D., *presiding*. (Lee Room, Virginia Wing).

WEDNESDAY AFTERNOON

1:30—Cancer Committee. Chauncey B. Wright, M. D., *presiding*. (Buchanan Room).

3:00—First Session of the House of Delegates. Albert C. Esposito, M. D., *presiding*. (Chesapeake Hall).

Invocation—The Rev. Eugene A. Schmitt, St. Charles Borromeo Church, White Sulphur Springs.

Address: James Z. Appel, M. D., President, American Medical Association.

Business Meeting.

THURSDAY MORNING

August 26

8:00—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—Richard J. Stevens, M. D., Chairman, Program Committee.

Invocation—Tracy N. Spencer, Jr., M. D.

Address of Welcome—Albert C. Esposito, M. D., President, West Virginia State Medical Association.

Address by Walter H. Judd, M. D.

First General Session

Moderator: Richard W. Corbitt, M. D.

9:45—R. Gordon Douglas, M. D., Emeritus Professor of Obstetrics and Gynecology, Cornell University Medical College, New York City; and Consultant in Obstetrics and Gynecology to the New York Hospital. Subject: "Amniocentesis and Intra-Uterine Transfusion in Rh Immunized Patients."

10:30—Thomas E. Shaffer, M. D., Professor of Pediatrics and Preventive Medicine, Ohio State University College of Medicine, Columbus; and Team Physician for Ohio State Athletic Teams. Subject: "The Adolescent Athlete."

11:15—Recess for Visiting Exhibits.

11:45—Cornelius E. Sedgwick, M. D., Member of the General Surgery Staff, Lahey Clinic Foundation, Boston, Massachusetts. Subject: "Portal Hypertension."

12:30—Recess for Lunch and Visiting Exhibits.

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. (Tyler Room).

THURSDAY AFTERNOON

2:00—Resolutions Committee. Maynard P. Pride, M. D., *presiding*. (West Virginia Room).

2:00—Section on Surgery. William E. Gilmore, M. D., *presiding*. (Mountaineer Room).

Guest Speaker: Cornelius E. Sedgwick, M. D., Boston. Subject: "Inflammatory Lesions of the Intestines."

2:00—Open Meeting, West Virginia State Society of Allergy. Myer Bogarad, M. D., *presiding*. (Governor's Hall).

Guest Speakers: Claude A. Frazier, M. D., Asheville, North Carolina. Subject: "Insect Sting Allergy and Its Management."

Nathan Schaffer, M. D., East Orange, New Jersey. Subject: "Modern Assessment of Therapy for Allergy Diseases—1965."

THURSDAY EVENING

6:00—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. Lee B. Todd, M. D., *in charge.* (West Virginia Room).

9:30—WESPAC Meeting. Speaker: Edward R. Annis, M. D., Past President of the American Medical Association. (Chesapeake Hall).

FRIDAY MORNING

August 27

8:15—Motion Pictures. John J. Mahood, M. D., *in charge.* (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: Jack Leckie, M. D.

9:00—William G. Thurman, M. D., Professor and Chairman of Pediatrics, University of Virginia School of Medicine, Charlottesville. Subject: "What to Do With the Bleeding Child."

9:45—Samuel D. McPherson, Jr., M. D., Clinical Professor of Ophthalmology and Acting Chief of the Division of Ophthalmology, University of North Carolina School of Medicine. Subject: "Some Ocular Signs of Systemic Disease."

10:30—Recess for Visiting Exhibits.

11:00—Leon Schiff, M. D., Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio. Subject: "The Differential Diagnosis of Jaundice."

11:45—Clinical Pathological Conference.

Moderator: Kenneth G. MacDonald, M. D.
Radiographic Findings: J. Dennis Kugel, M. D.
Clinical Discussant: Leon Schiff, M. D.
Pathologic Findings: Grover B. Swoyer, M. D.

12:30—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. Arnold J. Brody, M. D., *presiding.* (Governor's Hall).

Guest Speaker: Leon Schiff, M. D., Cincinnati. Subject: "The Use of Steroids in Liver Disease."

Business Meeting.

2:00—West Virginia Pediatric Society. Russell V. Lucas, M. D., *presiding.* (Tyler Room).

Guest Speakers: William G. Thurman, M. D., Charlottesville. Subject: "Recent Advances in the Management of Malignant Disease."

Thomas E. Shaffer, M. D., Columbus. Subject: "The Adolescent in Your Pediatric Practice."

2:00—West Virginia Obstetrical and Gynecological Society. Dwight P. Cruikshank, M. D., *presiding.* (Mountaineer Room).

Guest Speaker: R. Gordon Douglas, M. D., New York City. Subject: "Breech Presentation."

2:00—West Virginia Academy of Ophthalmology and Otolaryngology. R. Alan Fawcett, M. D., *presiding.* (Lee Room, Virginia Wing).

Guest Speaker: Samuel D. McPherson, Jr., M. D., Durham, North Carolina. Subject: "The Surgical Treatment of Chronic Open Angle Glaucoma."

2:00—Section on Orthopedic Surgery. Robert S. Wilson, M. D., *presiding.* (Van Buren Room).

Guest Speaker: Benjamin W. Drompp, M. D., Professor and Head, Division of Orthopedic Surgery, University of Arkansas Medical Center, Little Rock. Subject: "Current Concepts in the Surgery of Rheumatoid Arthritis."

2:00—Section on Urology. D. Franklin Milam, M. D., *presiding.* (Jackson Room).

There will be a discussion on "New Procedures in Urology at the West Virginia University Medical Center."

2:00—West Virginia Radiological Society. Joseph L. Curry, M. D., *presiding.* (Pierce Room).

Business Meeting and Film Session.

2:00—West Virginia Society of Anesthesiologists. Jerill D. Cavender, M. D., *presiding.* (Washington Room, Virginia Wing).

Guest Speaker: Paul E. Huffington, M. D., Morgantown. Subject: "The Logic of Fluid Replacement During Surgery."

2:00—Section on Neurology, Neurosurgery and Psychiatry. Carrel M. Caudill, M. D., *presiding.* (Buchanan Room).

Guest Speakers: Charles E. Goshen, M. D., and George R. Nugent, M. D., WVU School of Medicine, Morgantown. Subject: "Management Problems in Head Injuries."

3:00—West Virginia Chapter, American Society of Internal Medicine. A. B. Curry Ellison, M. D., *presiding*. (Governor's Hall).

Business Meeting.

5:00—Committee on Nominations. L. J. Pace, M. D., *presiding*. (Lee Room, Virginia Wing).

FRIDAY EVENING

10:00—Auxiliary Entertainment and Cabaret Dance. Music by "The Townsmen." (Chesapeake Hall).

SATURDAY MORNING

August 28

8:00—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall).
8:30-2:30—Registration, Main Floor Lobby.

Symposium on "Emergency Maintenance of Life"

Moderator: Clark K. Sleeth, M. D.

Participants: Members of the Faculty at the West Virginia University School of Medicine.

9:00—N. W. B. Craythorne, M. D., Associate Professor and Chairman of the Division of Anesthesiology (Introductory Remarks).

9:20—Paul E. Huffington, M. D., Instructor in the Division of Anesthesiology. Subject: "Maintenance of the Airway."

9:30—Allen E. Yeakel, M. D., Associate Professor of Anesthesiology. Subject: "Respiratory Resuscitation."

9:55—Herbert E. Warden, M. D., Professor of Surgery. Subject: "Cardiovascular Resuscitation."

10:15—Recess for Visiting Exhibits.

10:45—N. W. B. Craythorne, M. D. Subject: "The Pharmacological Aspects of Cardiac Arrest."

11:00—Alphonse C. Edmundowicz, M. D., Assistant Professor of Medicine. Subject: "Electrical Defibrillation of the Heart."

11:10—Bernard Zimmermann, M. D., Professor and Chairman of the Department of Surgery. Subject: "The Management of Crushed Chest."

11:30—Alphonse C. Edmundowicz, M. D. Subject: "The Management of Life-Threatening Arrhythmias."

11:40—Question and Answer Period.

12:15—Recess for Lunch and Visiting Exhibits.

SATURDAY AFTERNOON

1:30—West Virginia Association of Pathologists. Grover B. Swoyer, M. D., *presiding*. (Jackson Room).

Business Meeting.

2:30—Second and Final Session of the House of Delegates. Albert C. Esposito, M. D., *presiding*. (Chesapeake Hall).

Invocation—William F. Beckner, M. D.

Presidential Address—Albert C. Esposito, M. D., President, West Virginia State Medical Association.

Introduction of President of Woman's Auxiliary and Honor Guests.

Introduction of Recipients of 1965 Medical Scholarship Awards.

Business Meeting.

Election of Officers.

Installation of Seigle W. Parks, M. D., of Charleston, as President of the West Virginia State Medical Association.

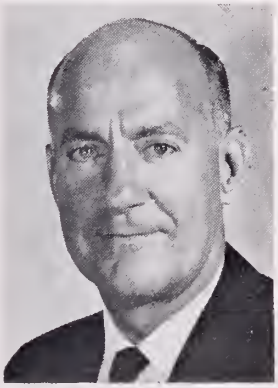
SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Edward R. Annis, M. D., of Miami, Florida, Past President of the American Medical Association, is a native of Detroit, Michigan.



Edward R. Annis, M. D.

He was graduated from the University of Detroit in 1933 and received his M. D. degree in 1938 from the Marquette University School of Medicine.

Doctor Annis has been active for many years in the affairs of local, state and national medical associations. He has served as Chairman of the Legislative Committee of the Florida State Medical Association and has served on the Board of Directors of Family Service and the Senior Citizens Division of the Welfare Planning Council. The National Conference of Christians and Jews awarded him the Brotherhood Medal in 1958.

Doctor Annis has served as Chief of the Department of Surgery at Mercy Hospital and attending physician at North Shore Hospital, both in Miami.

James Z. Appel, M. D., President of the American Medical Association, is a native of Lancaster, Pennsylvania, where he practices medicine.

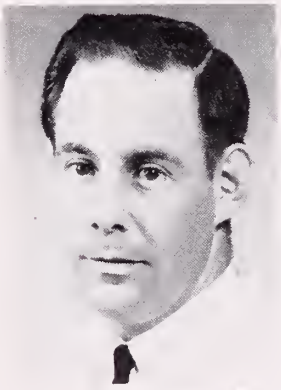
James Z. Appel, M. D.

Doctor Appel was graduated from Franklin and Marshall College. He received his M. D. degree in 1932 from the University of Pennsylvania School of Medicine. He is currently serving as president of the staff of the Lancaster General Hospital and as director of health services at Franklin and Marshall College.

He was elected a Delegate to the American Medical Association in 1945 and was named a member of the Board of Trustees in 1957. He had been Vice Chairman of the Board of Trustees since 1962, a position he relinquished upon being named President Elect at the clinical convention in Miami Beach in 1964.

Doctor Appel is Chairman of the Joint Commission on Accreditation of Hospitals and has served for the past two years as a United States Delegate to the World Health Organization.

N. W. B. Craythorne, M. D., of Morgantown, Chairman of the Division of Anesthesiology at the West Virginia University Medical Center, was born at Belfast, Northern Ireland.



N. W. B. Craythorne, M. D.

Doctor Craythorne received his M. D. degree in 1954 from Queen's University in Northern Ireland. He served residencies in anesthesiology at Belfast City Hospital and the University of Pennsylvania.

He was an Instructor in Anesthesiology at the University of Pennsylvania, 1958-1959, and became Associate Professor and Acting Chairman of the Division of Anesthesiology at WVU in 1961. He was named Chairman on July 1, 1962.

Doctor Craythorne also has served as Clinical Assistant at Royal Victoria Hospital in Montreal, Demonstrator in Anesthesia at McGill University and Consultant Anesthetist at various other hospitals and medical facilities.

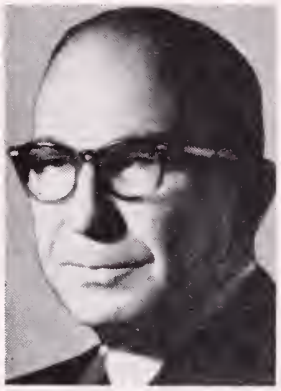
Heavy Room Reservations At The Greenbrier

Reservations for the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28, are approaching the 500 mark as this issue of *The Journal* goes to press.

The management has again assured Association officials that every effort will be made to arrange accommodations for all those who are interested in attending the convention. It is important, however, that reservations be made as soon as possible so that some idea may be had by the management concerning the total number of rooms that will be needed to house those attending the meeting.

Requests for rooms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, W. Va.

R. Gordon Douglas, M. D., of New York City, Emeritus Professor of Obstetrics and Gynecology at Cornell University Medical College, was born in Winnipeg, Canada.



R. Gordon Douglas, M. D.

Doctor Douglas, who also serves as Consultant in Obstetrics and Gynecology at the New York Hospital, attended the University of Alberta and received his M. D. degree in 1924 from McGill University Faculty of Medicine in Montreal.

He had postgraduate training at the Montreal General Hospital and continued his training in obstetrics and gynecology at the Johns Hopkins University Hospital in Baltimore. He had a year's study in bacteriology at the University of Rochester School of Medicine and a second year at several clinics in Europe.

Doctor Douglas joined the staff of the Cornell University Medical College and The New York Hospital in 1931. He also serves as Honorary Consulting Surgeon to the Royal Women's Hospital in Melbourne, Australia.

He is a past president of the New York Obstetrical Society, American Association of Obstetricians and Gynecologists, and the American College of Obstetricians and Gynecologists. He also is a past president of the Section on Obstetrics and Gynecology of the American Medical Association, and is currently serving as first vice president of the American Board of Obstetrics and Gynecology.

He has had numerous papers published in scientific journals on subjects in the field of obstetrics and gynecology.

Benjamin W. Drompp, M. D., of Little Rock, Arkansas, who is Professor and Head of the Division of Orthopedic Surgery at the University of Arkansas Medical Center, was born in Logansport, Indiana.

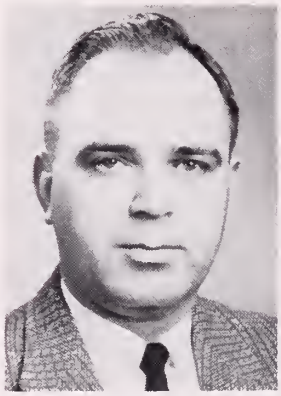
Benjamin W. Drompp, M. D.

He was graduated from Wayne State University and received his M. D. degree in 1953 from Wayne State University College of Medicine. He served his internship and had residency training at several hospitals in Detroit.

He joined the faculty of Wayne State University College of Medicine in 1958 and was serving as Associate Professor of Orthopedic Surgery when he accepted his present appointment at the University of Arkansas Medical Center in 1962. He also serves as Chief Consultant in Orthopedic Surgery at the VA Hospital in Little Rock.

He was certified by the American Board of Orthopedic Surgery in 1960 and is the author of numerous papers which have appeared in professional journals.

Alphonse C. Edmundowicz, M. D., Assistant Professor of Medicine at the West Virginia University School of Medicine, is a native of Nanticoke, Pennsylvania.



A. C. Edmundowicz, M. D.

Doctor Edmundowicz was graduated from Villanova and received his M. D. degree in 1955 from Hahnemann Medical College. He served a residency in internal medicine at Geisinger Memorial Hospital and was a Fellow in Internal Medicine at the Mayo Clinic.

Also at the Mayo Clinic, Doctor Edmundowicz was Staff Assistant in Cardiovascular Physiology and Staff Assistant in Clinical Cardiology. He is a member of the West Virginia State and American Medical Associations.

Claude A. Frazier, M. D., who practices his specialty of allergy at Asheville, North Carolina, is a native of West Virginia.

Claude A. Frazier, M. D.

Doctor Frazier, who is a member of the Editorial Board of *A Review of Allergy and Applied Immunology* and a past editor of the Allergy Section of the *Southern Medical Journal*, received his M. D. degree in 1944 from the Medical College of Virginia.

He received his allergy training at the Roosevelt Hospital in New York City and was certified by the American Board of Pediatrics in 1952.

He will present a paper on "Insect Sting Allergy and Its Management" before a meeting of the West Virginia State Society of Allergy on Thursday afternoon, August 26.

Charles E. Goshen, M. D., of Morgantown, Associate Professor of Psychiatry at the West Virginia University School of Medicine since November of 1961, is a native of Altoona, Pennsylvania.

Charles E. Goshen, M. D.

Doctor Goshen received his A. B. degree in 1938 from Columbia University and his M. D. degree in 1942 from the Columbia University College of Physicians and Surgeons. He served residencies in psychiatry at Central Islip State Hospital, Mitchell Field Air Force Regional Hospital and Bronx Veterans Hospital, all in New York. He was certified in 1948 by the American Board of Psychiatry and Neurology.

Doctor Goshen served as Research Director of the central office of the American Psychiatric Association in Washington, D. C., 1957-59, and was responsible for the organization and direction of two projects on postgraduate training for physicians and architectural study of psychiatric hospitals. He also has served as a part-time member of the psychiatric faculties at Johns Hopkins University School of Medicine and the George Washington University School of Medicine.

He is a Fellow of the American Psychiatric Association, and a member of the American Medical Association, the Association of American Medical Writers and other organizations.

Doctor Goshen is the author—or co-author—of five books and more than 50 articles in professional journals.

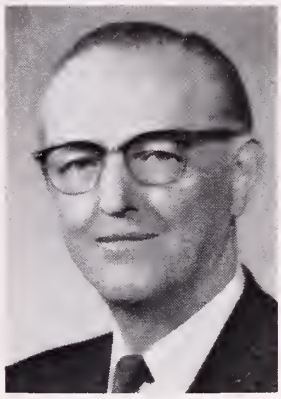
Paul E. Huffington, Jr., M. D., Instructor in Anesthesiology at the West Virginia University School of Medicine, joined the faculty in 1964.

Paul E. Huffington, Jr., M. D.

Doctor Huffington attended Baltimore City College and Duke University and received his M. D. degree from the University of Maryland. He interned at St. Luke's Hospital in Denver and served residencies at Parkland Memorial Hospital in Dallas, Texas, and at the West Virginia University Medical Center.

His professional memberships include the American Society of Anesthesiologists and the American Medical Association.

Walter H. Judd, M. D., of Washington, D. C., who is a former congressman from Minnesota and a medical missionary, was born at Rising City, Nebraska.


Walter H. Judd, M. D.

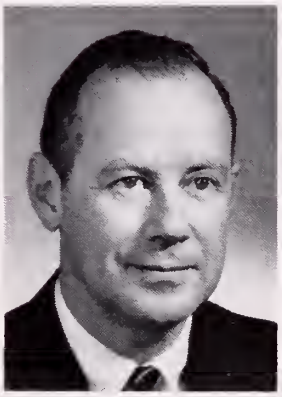
Doctor Judd received his M. D. degree in 1923 from the University of Nebraska School of Medicine. He had postgraduate training at The Mayo Foundation of the University of Minnesota and then served in China as a medical missionary.

Doctor Judd returned from China in 1938 and spent the next two years speaking throughout the United States in an attempt to arouse Americans to the menace of Japanese military expansion and the threat to world peace of communist subversion in China.

Following two years of private practice in Minneapolis, he was a successful candidate for Congress from Minnesota's Fifth Congressional District. He served ten terms in the House of Representatives and is a nationally recognized authority on U. S. foreign policy.

Doctor Judd has been active for many years in organized medicine and is currently serving as a member of the Judicial Council of the American Medical Association. He was the recipient of the AMA Distinguished Service Award in 1961.

Samuel D. McPherson, Jr., M. D., of Durham, North Carolina, Clinical Professor of Ophthalmology and Acting Chief of the Division of Ophthalmology, University of North Carolina School of Medicine, is a native of Durham. He was graduated from the University of North Carolina and received his M. D. degree in 1943 from the Johns Hopkins School of Medicine. He served as House Officer, Assistant Resident, and Resident Ophthalmologist to the Wilmer Institute of the Johns Hopkins Hospital, 1944-48. He was certified by the American Board of Ophthalmology in 1948 and he is a Fellow of the American College of Surgeons and a member of the American Medical Association.


S. D. McPherson, Jr., M. D.

Doctor McPherson is Chief of Staff at McPherson Hospital in Durham and is consulting ophthalmologist at Lincoln Hospital and attending ophthalmologist at Watts Hospital, both in Durham.

Leon Schiff, M. D., of Cincinnati, Professor of Medicine at the University of Cincinnati College of Medicine, was born at Riga, Latvia.

Leon Schiff, M. D.

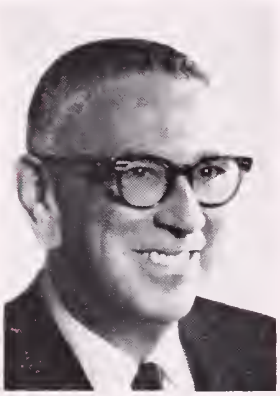
Doctor Schiff was graduated from the University of Cincinnati and received his M. D. degree in 1924 from the University of Cincinnati College of Medicine. He also received a Ph.D. degree in 1929 from the same college. He served an internship and had residency training at Cincinnati General Hospital and also had postgraduate training in Germany.

He joined the faculty of the University of Cincinnati College of Medicine in 1930 and was named Professor of Medicine in 1958. He also has served since 1938 as Director of the Gastric Laboratory at Cincinnati General Hospital.

He is the author of several books, including the "*Differential Diagnosis of Jaundice*" and "*Clinical Approach to Jaundice.*" He also is the author of numerous papers dealing with liver and digestive tract diseases.

Doctor Schiff is a Fellow of the American College of Physicians and a Past President of the American Association for the Study of Liver Diseases.

Nathan Schaffer, M. D., of East Orange, New Jersey, is Chief of Allergy at the East Orange General Hospital in that city. Doctor Schaffer was graduated from the University of Michigan in 1927 and received his M. D. degree in 1930 from the University of Michigan School of Medicine. He interned at University Hospital in Ann Arbor and served a residency at Newark Beth Israel Hospital in Newark, New Jersey.

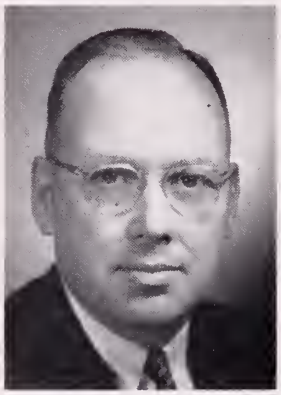


Nathan Schaffer, M. D.

He also serves as Associate in Allergy and Former Chief of the Allergy Clinic at Orange Memorial Hospital in Orange, New Jersey. He is currently serving as second vice president of the American College of Allergy and he is a past president of the New Jersey Allergy Society. He also serves as chairman of the Committee on Aero-Biology of the American College of Allergy.

Doctor Schaffer will present a paper on "Modern Assessment of Therapy for Allergy Diseases—1965" before a meeting the West Virginia State Society of Allergy on Thursday afternoon, August 26.

Cornelius E. Sedgwick, M. D., of Boston, a member of the staff of Lahey Clinic, was born in New York City.



Cornelius E. Sedgwick, M. D.

Doctor Sedgwick received his M. D. degree in 1940 from Cornell University Medical College. He interned and served a residency at Roosevelt Hospital in New York City. He also served a Fellowship in Surgery at the Lahey Clinic, 1947-48.

He served as a Captain in the Medical Corps of the U. S. Army, 1942-45, and joined the staff of the Lahey Clinic in 1948.

He was certified by the American Board of Surgery in 1950 and is a member of the American Medical Association, American College of Surgeons, Boston Surgical Society and New England Surgical Society.

Thomas E. Shaffer, M. D., of Columbus, Professor of Pediatrics and Preventive Medicine at Ohio State University College of Medicine, was born in Asaph, Pennsylvania.

Thomas E. Shaffer, M. D.

Doctor Shaffer was graduated from Cornell University and received his M. D. degree in 1932 from Cornell University Medical College.

Doctor Shaffer served as an Instructor in Pediatrics at the Yale University School of Medicine from 1936 to 1942 and during that period was also engaged in private practice in New Haven, Connecticut. He served for four years as a Major in the Medical Corps of the U. S. Army.

He joined the faculty at Ohio State in 1946 and has been there ever since except for a one-year period during which he served as Professor of Preventive Pediatrics at Temple University School of Medicine. He also served for four years as Director of Medical Services of the State of Ohio Juvenile Diagnostic Center before returning to full-time duties at Ohio State last August.

Doctor Shaffer is a member of the AMA Committee on the Medical Aspects of Sports and in 1964 was awarded the William G. Anderson Award by the American Association of Health, Physical Education and Recreation "in recognition of meritorious service to the Profession of Health, Physical Education and Recreation."

William G. Thurman, M. D., of Charlottesville, Virginia, Professor and Chairman of the Department of Pediatrics at the University of Virginia School of Medicine, is a native of Jacksonville, Florida.

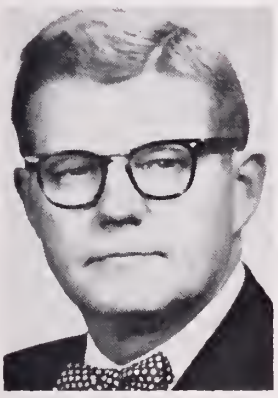
William G. Thurman, M. D.

He received his M. D. degree in 1953 from the McGill University School of Medicine in Montreal. He interned at City Hospital in Columbus, Georgia, and served a residency at Charity Hospital in New Orleans and a fellowship in pediatric hematology at the Tulane University School of Medicine and Children's Hospital of Michigan.

Prior to joining the faculty at the University of Virginia School of Medicine in 1964, Doctor Thurman served as Instructor and Assistant Professor at the Tulane University School of Medicine and Emory University School of Medicine; and as Chairman of the Department of Pediatrics at Memorial Sloan-Kettering Cancer Center in New York City. He also served as Professor of Pediatrics at Cornell University Medical College.

He was certified by the American Board of Pediatrics in 1960 and is a member of the American Society of Hematology, American Society of Human Genetics, American Academy of Pediatrics and the American Association of Advancement of Science.

Herbert E. Warden, M. D., Professor of Surgery at the West Virginia University Medical Center and Attending Surgeon at University Hospital, was born in Cleveland. Doctor Warden attended Washington and Jefferson College and received his M. D. degree in 1946 from the University of Chicago School of Medicine.



Herbert E. Warden, M. D.

Before joining the WVU School of Medicine Staff in 1960, Doctor Warden served an assistant residency and residency at University of Minnesota Hospitals. He held various research and academic posts at the University of Minnesota.

He is certified by the American Board of Surgery and the Board of Thoracic Surgery. Doctor Warden's professional memberships include the American Medical Association, the Society of University Surgeons and the American Society of Surgeons.

Allen E. Yeakel, M. D., of Morgantown, Assistant Professor in the Division of Anesthesiology at the West Virginia University Medical Center, is a native of Fair Oaks, Pennsylvania.

Allen E. Yeakel, M. D.

Doctor Yeakel received a degree in physics from Carnegie Institute of Technology and was awarded his M. D. degree in 1951 at the University of Pennsylvania School of Medicine.

Before joining the faculty at the WVU School of Medicine, Doctor Yeakel practiced medicine at Bechtelsville, Pennsylvania, 1953-59, and later was Assistant Instructor in the Department of Anesthesiology at the University of Pennsylvania School of Medicine.

He served a general practice residency at Sacred Heart Hospital in Norristown, Pennsylvania, and a residency in anesthesiology at the Hospital of the University of Pennsylvania.

Bernard Zimmermann, M. D., of Morgantown, Professor and Chairman of the Department of Surgery at the West Virginia University School of Medicine since 1960, is a native of St. Paul, Minnesota. Doctor Zimmermann attended Harvard University and received his M. D. degree in 1945 from the Harvard Medical School. He received a Ph.D. degree in surgery in 1953 from the University of Minnesota Medical School.

Bernard Zimmermann, M. D.

Before going to WVU, Doctor Zimmermann served as Professor of Surgery at the University of Minnesota Medical School.

A prolific contributor to medical literature, Doctor Zimmermann is the author or co-author of more than 75 scientific papers, monographs and texts.

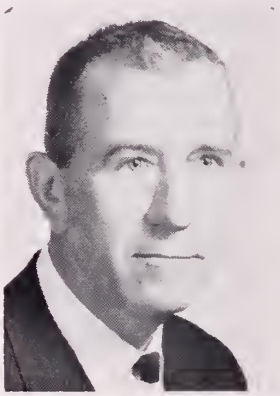
His professional memberships include the American College of Surgeons, the American Surgical Socity, The Halsted Society and the Society of University Surgeons. He is certified by the American Board of Surgery and the Board of Thoracic Surgery.

Doctor Zimmermann has served as Secretary-Treasurer of the Minnesota Academy of Medicine, President of the Section on Surgery of the West Virginia State Medical Association and President of the West Virginia Division, American Cancer Society.

1965 PROGRAM COMMITTEE

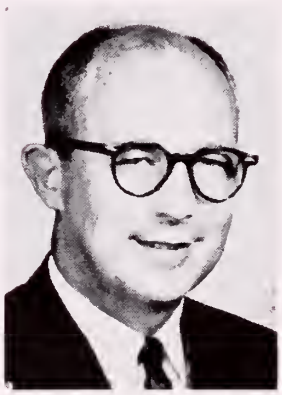
Richard J. Stevens, M. D.
Huntington
Chairman

Richard W. Corbitt, M. D.
Parkersburg

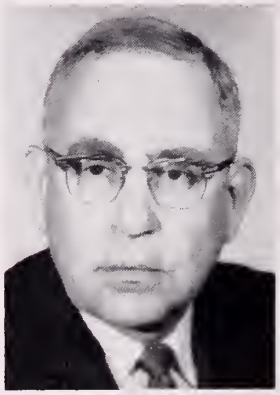


Jack Leckie, M. D.
Huntington

Kenneth G. MacDonald, M. D.
Charleston



Maynard P. Pride, M. D.
Morgantown



Clark K. Sleeth, M. D.
Morgantown

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, G. E. Hartle, Philippi; Charles L. Leonard, Elkins; and A. Kyle Bush, Philippi. Alternates, Cora C. Lenox, Philippi; Homer D. Martin, Dailey; and Raymond W. Cronlund, Philippi.

BOONE (2)—Delegates, David E. Wallace and Harold H. Howell, Madison. Alternates, William S. Cooley, Wharton; and W. V. Wilkerson, Whitesville.

BROOKE (2)—Delegates, J. P. McMullen and W. T. Booher, Wellsburg. Alternates, W. T. Booher, Jr., Wellsburg; and James E. Wise, Follansbee.

CABELL (8)—Delegates, John F. Otto, Jr., Walter R. Wilkinson, Thomas J. Holbrook, Thomas F. Scott, John M. Bobbitt, Gerald J. Eder, Huntington; W. D. Bourn, Barboursville; and C. Stafford Clay, Huntington. Alternates, W. L. Neal, James P. Carey, I. Ewen Taylor, Thomas G. Folsom, Jack Leckie, Clarence H. Boso, Roy A. Edwards, Jr., and Joseph E. Ricketts, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, Ira F. Hartman, Buckhannon; J. E. Echols, Richwood; and J. C. Huffman, Buckhannon. Alternates, R. L. Chamberlain, Buckhannon; W. W. Huffman, Gassaway; and Charles T. Lively, Weston.

EASTERN PANHANDLE (3)—Delegates, Halvard Wanger and S. Elizabeth McFetridge, Shepherdstown; and L. Mildred Williams, Charles Town. Alternates, Clyde A. Burgess, Berkeley Springs; L. Walter Fix and E. Walter Rice, Martinsburg.

FAYETTE (2)—Delegates, W. P. Bittinger, Oak Hill; and R. S. Birckhead, Gauley Bridge. Alternates, Joe N. Jarrett, Ivan H. Bush, Jr., and D. Alene Blake, Oak Hill; and W. B. Davis, Rainelle.

GREENBRIER VALLEY (3)—Delegates, Paul E. Prillaman, Jr., Ronceverte; Don F. Shreve, White Sulphur Springs; and Claude L. Houck, Lewisburg. Alternate, Arnold J. Brody, White Sulphur Springs.

HANCOCK (3)—Delegates, J. L. Thompson, Meyer Bogarad and Richard E. Flood, Weirton. Alternate, D. S. Pugh, Chester.

HARRISON (4)—Delegates, James A. Thompson, Andrew J. Weaver, Richard K. Hanifan and L. Dale Simmons, Clarksburg. Alternates, A. Robert Marks, Robert S. Wilson, Herman Fischer and Robert D. Hess, Clarksburg.

KANAWHA (13)—Delegates, George R. Callender, Henry R. Glass, Jr., George L. Grubb, Charleston; Edward Jackson, St. Albans; J. Dennis Kugel, Milton J. Lilly, Jr., Charleston; Richard C. Wallace, St. Albans; and A. B. Curry Ellison, Jerill D. Cavender, James H. Getzen, Kenneth G. MacDonald, Theodore P. Mantz and William B. Rossman, Charleston. Alternates, Robert C. Bock, Charleston; Norman Bsharah, Poca; Duke A. Dent, Charleston; Leonard M. Eckmann, South Charleston; Andrew W. Goodwin, II, and Carl B. Hall, Charleston; O. M. Harper, Clendenin; James S. Kessel, Ripley; Richard A. Lewis, Charleston; William R. Rice, Dunbar; and Page H. Seekford, Robert E. Stone and Pat A. Tuckwiller, Charleston.

LOGAN (3)—Delegates, Kwan H. Lee, Logan; Harold Van Hoose, Man; and Everett H. Starcher, Logan. Alternates, Abraham Tow, Logan; Thomas P. Long, Man; and Ray M. Kessel, Logan.

MARION (3)—Delegates, Robert R. Frye, Mannington; and Rupert W. Powell and G. Thomas Evans, Fairmont. Alternates, Jack Calvin Morgan, Joseph T. Mallamo and Louis E. Baron, Fairmont.

MARSHALL (2)—Delegates, Andrew J. Barger, Glen Dale; and J. W. Myers, Moundsville. Alternate, William P. Bradford.

MASON (2)—Delegates, Richard L. Slack and C. Leonard Brown, Pt. Pleasant. Alternate, Dan Glassman, Pt. Pleasant.

McDOWELL (3)—Delegates, David J. Skewes, J. Hunter Smith and A. J. Villani, Welch. Alternates, R. H. Edwards, Guy E. Irvin and Charles F. McCord, Welch.

MERCER (4)—Delegates, John J. Mahood, Wade H. St. Clair, Jr., E. W. McCauley and Upshur Higginbotham, Bluefield. Alternates, David F. Bell, Jr., and E. Lyle Gage, Bluefield; and John I. Markell, Princeton.

MINGO (2)—Delegates, L. Lake Swigart and Arthur E. Levy, Williamson. Alternates, Robert J. Tchou and Russell A. Salton, Williamson.

MONONGALIA (4)—Delegates, William E. King, D. Franklin Milam, George A. Curry and Charles E. Andrews, Morgantown. Alternates, Robert J. Fleming, Clark K. Sleeth, Ralph W. Ryan and Arthur W. Kelley, Morgantown.

OHIO (6)—Delegates, R. U. Drinkard, John P. Griffith, Jr., Herman Rubin, James E. Spargo, Howard G. Weiler and H. S. Weeks, Jr., Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, Delmer J. Brown, Richard W. Corbitt, S. William Goff, E. B. Holmes, and Lyle D. Vincent, Parkersburg. Alternates, Ralph H. Boone, Sistersville; Fay Perry Greene, Jr., Parkersburg; Asel P. Hatfield, Harrisville; Charles W. Thacker and W. R. Yeager, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Vernon L. Dyer, Petersburg; Charles J. Sites, Franklin; and Harry F. Coffman, Keyser. Alternate, Russell E. Straub, Romney.

SUMMERS (2)—Delegates, Buford W. McNeer and Jack D. Woodrum, Hinton. Alternates, A. W. Holmes and James W. Stokes, Hinton.

TAYLOR (2)—Delegates, Herbert N. Shanes and C. A. Haislip, Grafton. Alternates, Wallace B. Murphy and R. D. Stout, Grafton.

WETZEL (2)—Delegates, Lemoyne Coffield and T. B. Gordon, New Martinsville. Alternates, Kent M. Hornbrook and John O. Theiss, New Martinsville.

WYOMING (2)—Delegates, Mario Cardenas and Ross E. Newman, Mullens. Alternates, Ward Wylie and Byron W. Steele, Mullens.

PRESTON (2)—Delegates, Donald P. Brown and James V. Gainer, Jr., Kingwood. Alternates, Del Roy R. Davis, Kingwood; and William H. Harriman, Jr., Terra Alta.

RALEIGH (4)—Delegates, Worthy W. McKinney, Warren D. Elliott, W. Fred Richmond and Grover C. Hedrick, Jr., Beckley. Alternates, W. H. Rardin, Asa Barnes, Charles W. Merritt and Richard G. Starr, Beckley.

Reception Committee

James S. Klumpp, *Chairman*

C. A. Hoffman
Frank J. Holroyd
L. J. Pace
J. P. McMullen
George F. Evans
Thomas L. Harris
Russel Kessel
Thomas G. Reed

Albert C. Esposito
D. E. Greeneltch
John W. Hash
Kenneth G. MacDonald
William E. Gilmore
Walter R. Wilkinson

Dwight P. Cruikshank
Daniel E. Mairs
A. J. Villani
Richard W. Corbitt
Henry R. Glass, Jr.
J. W. Hesen, Jr.
I. Ewen Taylor
Gilbert A. Ratcliff

Richard J. Stevens
Arnold J. Brody
E. L. Crumpacker
R. Alan Fawcett
Nime K. Joseph
Worthy W. McKinney
Russell V. Lucas, Jr.
Meryleen B. Smith

W. Gene Klingberg
W. H. Rardin
Jerill D. Cavender
Harry S. Weeks, Jr.
Newman H. Newhouse
Hu C. Myers

F. Lloyd Blair
Francis L. Coffey
Theodore P. Mantz
J. C. Huffman
Charles L. Goodhand
William K. Marple
Kathryn P. Noble
Seigle W. Parks

Official Program

WOMAN'S AUXILIARY

to the

West Virginia State Medical Association
41st Annual Meeting

The Greenbrier
White Sulphur Springs
August 26-28, 1965

WEDNESDAY

August 25

3:00 P. M.—First Session of the House of Delegates, State Medical Association. (Chesapeake Hall).

Address by James Z. Appel, M. D., President of the American Medical Association. Auxiliary members are invited and urged to attend.

4:00 P. M.—Pre-Convention Board Meeting (Pierce Room). Mrs. George A. Curry, President, *presiding.*

THURSDAY MORNING

August 26

9:00—Formal Opening of the 98th Annual Meeting of the West Virginia State Medical Association.

Address by Walter H. Judd, M. D., Former U. S. Congressman and Medical Missionary.

All Auxiliary members are invited to attend. (Governor's Hall).

9:45—Formal Opening of the Convention, Mrs. George A. Curry, President, *presiding.* (Fillmore and Van Buren Rooms).

Invocation and Pledge of Loyalty, Mrs. J. C. Huffman.

Introduction of Honor Guests.

Presentation of Albert C. Esposito, M. D., President, West Virginia State Medical Association.

Introduction of Convention Chairmen, Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming.

Roll Call of Delegates, Mrs. Robert J. Tchou.

Convention Rules of Order, Mrs. Ralph W. Ryan, Parliamentarian.

Treasurer's Report, Mrs. J. Dennis Kugel.

In Memoriam, Mrs. D. E. Greeneltch.
Vocal Solo, Mrs. Andrew J. Weaver.

Credentials and Registration, Mrs. Maynard P. Pride.

Keynote Address—Mrs. Richard A. Sutter, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting, Mrs. George A. Curry.

New Business and Announcements.
Report of Revisions Committee, Mrs. William A. Thornhill, Jr.

Report of Nominating Committee, First Reading, Mrs. Pat A. Tuckwiller, Chairman.

Election of 1966 Nominating Committee.

*Reports of Officers:

President—Mrs. George A. Curry.

President Elect—Mrs. Wilson P. Smith.

First Vice President—Mrs. Herbert N. Shanes.

Second Vice President—Mrs. Chesterfield J. Holley.

Third Vice President—Mrs. John A. B. Holt.

Fourth Vice President—Mrs. Ray M. Kessel.

Treasurer—Mrs. J. Dennis Kugel.

Recording Secretary—Mrs. Robert J. Tchou.

*Reports of Standing Committees:

AMA-ERF—Mrs. Joe N. Jarrett.

Archives and History—Mrs. Charles L. Goodhand.

By-Laws and Handbook—Mrs. William A. Thornhill, Jr.

Disaster Preparedness and Safety—Mrs. Lysle T. Veach.

Community Service and International Health Activities—Mrs. A. C. Chandler.

Convention—Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming.

Editor, State News Bulletin—Mrs. W. Merle Warman.

Circulation Manager—Mrs. James Hugh Wiley.

Finance—Mrs. H. E. Beard.

Health Careers—Mrs. Charles H. Hiles.

Legislation—Mrs. L. Dale Simmons.

Liaison to WASAMA—Mrs. Clark K. Sleeth.

Members-at-Large—Mrs. Buford W. McNeer.

Mental Health—Mrs. John W. Hash.

National Bulletin—Mrs. Charles S. Harrison.

Necrology—Mrs. D. E. Greeneltch.

Press and Publicity—Mrs. Rupert W. Powell.
Program—Mrs. Harry S. Weeks, Jr.
Resolutions—Mrs. C. R. Davisson.

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*These reports are not read but published in the Annual Reports Book.

Rural Health and Nutrition—Mrs. Lynwood D. Zinn.

Southern Medical Councilor—Mrs. Ross P. Daniel.

Presentation of County Presidents:
Boone—Mrs. Harold H. Howell.
Cabell—Mrs. Bruce M. Martin.
Central West Virginia—Mrs. E. H. Hunter.
Eastern Panhandle—Mrs. L. Walter Fix.
Fayette—Mrs. Ivan H. Bush.
Greenbrier Valley—Mrs. George Ferrell.
Hancock—Mrs. Leonard E. Yurko.
Harrison—Mrs. John D. H. Wilson.
Kanawha—Mrs. Earl A. McCowen.
Logan—Mrs. David Mullins.
Marion—Mrs. Franklin W. Mallamo.
McDowell—Mrs. J. Hunter Smith.
Mercer—Mrs. J. E. McCary
Mingo—Mrs. A. H. Henderson.
Monongalia—Mrs. Arthur W. Kelley.
Ohio—Mrs. C. B. Buffington.
Potomac Valley—Mrs. Robert W. Bess, Jr.
Preston—Mrs. William H. Harriman, Jr.
Raleigh—Mrs. Charles W. Merritt.
Taylor—Mrs. Herbert N. Shanes.
Wood—Mrs. Lyle D. Vincent.
Wyoming—Mrs. Byron W. Steele.

"Parliamentary Procedure."—Skit by Cabell County Auxiliary.

THURSDAY AFTERNOON

1:00—Luncheon for Wives of Visiting State Presidents—Mrs. G. A. Curry and Mrs. W. P. Smith, Hostesses.

2:30—Bridge Party.

Visit the Exhibits. Exhibit Center Open Until 3:30 P. M.

THURSDAY NIGHT

9:30—WESPAC Meeting.

Speaker: Edward R. Annis, M. D., Past President of the American Medical Association.

FRIDAY MORNING

August 27

8:00—Past President's Breakfast, Mrs. Pat A. Tuckwiller, Immediate Past President, *presiding*. (Director's Room).

9:30—Second General Session, Mrs. George A. Curry, President, *presiding*. (Fillmore and Van Buren Rooms).

Invocation—Mrs. Lynwood D. Zinn.

Introduction of Honor Guests.

Roll Call—Mrs. Robert J. Tchou.

Address—Mrs. Jordan Kelling, President, Woman's Auxiliary to the Southern Medical Association.

Presentation of Edward R. Annis, M. D., Past President of the American Medical Association.

Report of Reading Committee—Mrs. L. Dale Simmons.

Convention Announcements—Mrs. Clark K. Sleeth.

Reports of Convention Committees:
Finance—Mrs. Harry E. Beard.
Courtesy Resolutions—Mrs. Ross P. Daniel.
Credentials and Registration—Mrs. Maynard P. Pride.
Press and Publicity—Mrs. Rupert W. Powell.
Report of Nominating Committee—Mrs. Pat A. Tuckwiller.

Election of Officers.

Installation of Officers, Mrs. Richard A. Sutter, President of the Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. George A. Curry.

Presentation of Past President's Pin—Mrs. Pat A. Tuckwiller.

Inaugural Address—Mrs. Wilson P. Smith.

FRIDAY AFTERNOON

12:30—Luncheon for Members-At-Large—Mrs. Buford W. McNeer, Chairman.

1:00—Golf Tournament.

Visit the Exhibits. Exhibit Center Open Until 3:30 P. M.

FRIDAY NIGHT

10:00 P. M.-1:00 A. M.—41st Anniversary Ball. (Chesapeake Hall).

SATURDAY MORNING

August 28

10:00—Post-Convention Conference and Board Meeting. Mrs. Wilson P. Smith, President, *presiding*. (Fillmore and Van Buren Rooms).

SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates. (Chesapeake Hall).

Annual Address by the President, Albert C. Esposito, M. D., Huntington.

All Auxiliary members are invited and urged to attend.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

SCIENTIFIC EXHIBITS

(Exhibit Center)

ACUTE LEUKEMIA COOPERATIVE GROUP B

Recent advancements in the treatment of leukemia, lymphoma, myeloma, and childhood solid tumors are presented. Deliberate study plans have provided significantly improved survival, more frequent remission, and new facts to provide basis for investigations in patients and in the laboratory. New therapies are evolving. Ambulatory patient care is conducted cooperatively with the family physician, and all benefit from the clinical research.

John B. Harley, M. D.

AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

This exhibit will focus on the scientific publications and materials which the American Cancer Society makes available to doctors. Representatives in attendance will be more than willing to help doctors order whatever materials they wish.

William A. Nichols, Executive Director.

APPLICATION OF RADIOACTIVE ISOTOPES IN BRAIN SCANNING

Brain scanning with radioactive isotopes has firmly established itself as one of the reliable diagnostic tools in neurosurgical problems. Pneumoencephalography and angiography are augmented by the brain scan which in many instances has clarified an otherwise obscure problem. Lack of morbidity with this procedure allows this tool to be used as an outpatient screening procedure. The exhibit will demonstrate actual brain scans and in several instances correlate the scan with other diagnostic procedures. Radicactive mercury in the forms of Chlormedrin^{203} and Chlormedrin^{197} have been used as the radioisotope in this procedure.

George G. Green, M. D.

COMPARATIVE ANALYSIS OF 300 NEEDLE PUNCTURES AND 300 CATHETER CAROTID ARTERIOGRAMS PERFORMED IN A COMMUNITY GENERAL HOSPITAL

Transaortic catheter techniques provide a versatile, dependable and relatively safe approach to arteriography of the cerebral circulation. Using a femoral artery insertion, the experienced arteriographer may perform arch aortography and selective arteriography of each carotid or subclavian—vertebral artery in the vast majority of patients (over 90 per cent in this series of 320 procedures). The exhibit will emphasize technique, applications and complications.

Joseph L. Curry, M. D., Willard J. Howland, M. D., Frank M. Hudson, M. D., and J. Speed Rogers, M. D.

DIVISION OF VOCATIONAL REHABILITATION

This exhibit will feature a presentation consisting of 80 color slides explaining the key role that Vocational Rehabilitation workers have been playing in President Johnson's "War on Poverty." The slide presentation brings out the point that Vocational Rehabilitation has been engaged in its own private "War on Poverty" since the state-federal program was first established in 1922.

F. Ray Power, Director.

MEDICINE AND RELIGION

This exhibit, prepared by the Department of Medicine and Religion of the American Medical Association, points out the purpose and goal of the State and County Medical Societies to bring physicians and clergymen into closer communication; the focus of attention being better total care of patients and parishioners. Additional and more detailed information about this program will be available in the form of booklets and leaflets.

Charles A. Hubbard, Field Representative.

THE MENOPAUSE, A DEFICIENCY DISEASE

The exhibit covers the deficiency of estrogens and progesterones that characterize the menopause, which can now be corrected. Estrogen and progesterone therapy to alleviate the multiple changes that occur, such as osteoporosis, increased coronary arteriosclerosis, atrophy of the skin, senile vaginitis, and involuntional melancholia, will be covered.

F. P. Rhoades, M. D., Detroit, Michigan.

THE NATIONAL FOUNDATION MARCH OF DIMES

Chemistry, Chromosomes and Congenital Anomalies —The exhibit presents by means of models, diagrams, and pictures the suggested relationship between deoxribonucleciec acid in chromosomes as inferred from bacterial genetics and the relationship between abnormal chromosome patterns and congenital anomalies. Available at the exhibit will be a bulletin which pre-

sents a discussion to indicate their interrelationship and to suggest an explanation for one cause of congenital anomalies. Other literature dealing with congenital birth defects will also be available at the exhibit.

Representatives: Charles W. Dawkins and T. Sterling Evans, Sr.

PRESERVE VISION—DETECT GLAUCOMA

This exhibit, prepared by the Neurological Sensory Disease Service Program of the Division of Chronic Diseases, U.S.P.H.S., presents the approved method of glaucoma detection for the general physician. The purpose of the exhibit is to encourage the routine testing of intra-ocular pressure as a part of the routine physical examination.

Ralph W. Ryan, M. D.

RADIOACTIVE BRAIN SCANNING—CLINICAL VALUE

Scintillation scanning for brain lesions has become a widely used diagnostic procedure in recent years and already holds a respected position of importance in diagnostic studies. The exhibit, by showing illustrative cases, will emphasize applications of brain scanning in various lesions including brain tumors, infarcts and subdural hematoma. Correlation will be made with other diagnostic procedures including cerebral angiography and ventriculography.

Frank M. Hudson, M. D., J. Speed Rogers, M. D., Willard J. Howland, M. D., and Joseph L. Curry, M. D.

RENOVASCULAR HYPERTENSION

Renal hypertension is the most common form of curable hypertension. It is estimated to constitute about 7 to 10 per cent of the hypertensive population. In recent years there has been great impetus in developing techniques in order to predict which patients will have alleviation of their hypertension through corrective renovascular surgery. On display is a logical sequence demonstrating certain techniques to establish the diagnosis of renovascular hypertension. Clinical features, laboratory examinations, radiographic procedures and urological techniques are illustrated. In addition, a new screening test (Angiotensin Infusion Test) is demonstrated with data obtained from our hypertension clinic. The current pathogenic mechanisms of renovascular hypertension (angiotensin and aldosterone) are illustrated.

Alfred K. Pfister, M. D., L. D. Curnutte, M. D., James H. Getzen, M. D., and William C. Stewart, M. D., Hypertension Clinic, Charleston Memorial Hospital.

SOCIAL SECURITY ADMINISTRATION

"Concepts of Disability Evaluation."—This display shows information of medical interest. It emphasizes the measure of disability for Social Security purposes and highlights the kind of medical information needed by a state team, including a physician and a vocational specialist, to decide whether your patient meets the Social Security definition of disability, which closely parallels permanent and total disability.

SURGICAL CORRECTION OF THE RHEUMATOID HAND

The entire subject of reconstruction of the rheumatoid arthritic deformity of the hand is reviewed and demonstrated with color transparencies, etc. The new radical metacarpophalangeal arthroplasty and reconstruction of the rheumatoid hand deformity is presented.

Jerome E. Adamson, M. D., Norfolk, Virginia.

TREATMENT OF FINGERTIP INJURIES

The purpose of this exhibit is to demonstrate the practical methods of treating pulp injuries and amputation injuries to the ends of the fingers and thumb. Demonstrated will be split and full thickness skin grafting, including cross finger pedicles, palmar flaps and free full thickness grafts. Practical methods for the various levels of amputation will be outlined.

Lawrance S. Miller, M. D.

WEST VIRGINIA ASSOCIATION OF MEDICAL ASSISTANTS

Members of the Association will distribute literature concerning the objectives of the organization.

WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH

WEST VIRGINIA DEPARTMENT OF MENTAL HEALTH

This exhibit consists of two panels. The larger panel, with illumination, depicts by use of a design the process of admission to a mental hospital as it used to be and as it is now. The smaller panel serves as a screen for the showing of color slides.

W. VA. CHAPTER, AMERICAN SOCIETY OF INTERNAL MEDICINE

WEST VIRGINIA DEPARTMENT OF HEALTH DIVISION OF DENTAL HEALTH

This exhibit pertains to dental caries, and its message relates to the more common problems and their effects. There are three illustrations depicting (1) a carious molar tooth, (2) the same carious tooth with an abscess and (3) the space existing after extraction of the tooth. Relative information is noted throughout each of the progressive stages exemplifying the disadvantages and complications arising from this disease.

WEST VIRGINIA HEART ASSOCIATION

Differential Diagnosis: Chest Pain—The West Virginia Heart Association Professional Education exhibit is designed to test the physician's diagnostic ability. Four panels with x-rays and electrocardiograms are correlated with a written history of each case. Physicians taking the test will not be required to turn in or sign anything. Take the test, check your answers and discuss any questions with the physician attendant. You may keep the test booklet containing the questions and answers.

West Virginia Wing at The Greenbrier

INDUSTRIAL EXHIBITS

(Exhibit Center)

ABBOTT LABORATORIES
North Chicago, Illinois

Booth 7

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

Representative: James B. Davis.

CIBA PHARMACEUTICAL COMPANY
Summit, New Jersey

Booth 8

The exhibit will feature Esidrix® (hydrochlorothiazide Ciba). Ciba representatives will discuss the benefits of this product in hypertension (alone and as concomitant therapy) and in various edematous states (congestive heart failure, toxemia of pregnancy, premenstrual edema, edema of pregnancy, steroid-induced edema, edema of obesity, nephrosis).

Representatives: W. Howley and R. Topper.

THE COCA-COLA COMPANY
Atlanta, Georgia

Booth 43

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Works, Ronceverte, West Virginia, and the Coca-Cola Company.

ENCYCLOPAEDIA BRITANNICA
Chicago, Illinois

Booth 30

Encyclopaedia Britannica welcomes delegates to the 98th Annual Meeting of the West Virginia State Medical Association and invites them to examine the great new edition of Britannica. Official delegates may now purchase this magnificant set at an offer available only at our convention exhibits. Visit Britannica's Booth 30 for free descriptive literature.

Representative: Richard Joumas.

FLINT LABORATORIES
Morton Grove, Illinois

Booth 29

Synthroid® (sodium levothyroxine) the pure thyroid hormone will be featured. A new injectable dosage will be introduced. Complete product information will be available.

Representatives: Richard Miller, Jerome Urda and E. J. Gould.

GEIGY PHARMACEUTICALS
Yonkers, New York

Booth 16

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardio-vascular disease as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity, and other disorders, which may be discussed with representatives in attendance.

Representatives: James Donovan, John Bushkar and Myron Anderson.

GREAT BOOKS OF THE WESTERN WORLD
Chicago, Illinois

Booth 20

The Great Ideas Program—A new advancement in liberal education, spanning 3,000 years of Western Thought from Homer and the Bible to the 20th Century featuring the master key to the Great Books—The Syntopicon. The revolutionary Syntopicon, a totally new basic reference work, accomplishes in the field of ideas what the dictionary does for words and the encyclopaedia in the field of facts.

HOSPITAL & PHYSICIANS SUPPLY COMPANY
Charleston, West Virginia

Booth 46

You are cordially invited to visit our Booth 46. Our exhibit will consist of the latest in Burdick's new Dual-Speed Electrocardiograph and ultrasonic units. New diagnostic instruments such as: Fibre-optic Otoscopes and the new revolutionary fibre-optic sigmoidoscope by Welch-Allyn, Castle autoclaves and lights. Also, all types of emergency resuscitation equipment. We sincerely thank you for your patronage this past year and shall look forward to visiting with you again.

Representatives: Robert E. Lee Frazier, Robert K. Thacker and Gordon H. Davis.

ELI LILLY AND COMPANY
Indianapolis, Indiana

Booth 44

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products and can offer you precise information on recent developments in Lilly research. You may be particularly interested in discussing Keflin® Cephalothin, or Aventyl® HCl, Nortriptyline Hydrochloride.

Representatives: W. F. Brannon and M. J. Warner.

McLAIN SURGICAL SUPPLY INC.
Charleston, West Virginia

Booth 24

We are featuring Diapulse, a new bioelectrical modality for the safe treatment of the entire patient through the stimulation of the host defense mechanism by pulsed high frequency therapy, without pyrexia. Also, for your perusal, we will display the new Beck-Lee EKG and many other new items.

Representatives: Jack Schwarz and Dick Hightower.

S. E. MASSENGILL COMPANY
Bristol, Tennessee

Booth 2

Best wishes from Massengill to the West Virginia State Medical Association for a most successful meeting. Our representatives will welcome the opportunity to discuss products of interest to you. On display will be several Massengill specialty preparations, and literature will be available, should you desire it.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

Representatives: A. E. Partridge, Jr., Charles Derbyshire and Fred Pyles.

THE MEDICAL ARTS SUPPLY CO.
Huntington, W. Va.

Booth 42

We cordially invite you to visit our Booth 42, where we will offer the first showing of the unique new Unimeter that will give you, in your office, accurate, rapid and dependable analysis of the following four blood chemistries: True Glucose, B.U.N., Cholesterol and Hemoglobin. These tests can be done by your office assistant with only a few minutes instruction in technique. We will also have a special showing of Snowden-Pencer "Diamond Jaw" instruments and Hyland Laboratories laboratory reagents.

Representatives: M. L. Clovis and Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The theme for the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharp & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Representatives: M. S. Robertson and M. J. Klopp.

MILAN PHARMACEUTICALS, INC.
Princeton, West Virginia

Booth 33

PFIZER LABORATORIES
New York City

Booth 15

The Pfizer Laboratories display has been specifically arranged for your convenience and to give you the maximum in quick service and product information. To make your visit worthwhile, technically trained Medical Service Representatives will be on hand to discuss with you the latest developments in Pfizer research.

Representatives: William Ferguson and Larry Hodge.

PHYSICIANS NATIONWIDE, INC.
Charleston, W. Va.

Booth 22

Physicians Nationwide, Inc., is an association of Northwestern Mutual Life Insurance Agents—coast to coast—who specialize in working with physicians. Their objective is to provide professional services to the physician in estate and financial planning. The regional vice presidents for West Virginia are Hugh Thompson and Pete White. They welcome an opportunity to answer your questions and explain the services of PNI.

Representatives: Hugh Thompson and Pete White.

WM. P. POYTHRESS & CO., INC.
Richmond, Virginia

Booth 3

Mudrane, established Poythress combination for relief of bronchial asthma, and its new companion products, Mudrane GG Tablets and Mudrane GG Elixir, will be featured at the Poythress exhibit in Booth 3. Solfoton, Solfo-Serpine, Trocinate, Panalgesic and Synirin also will be featured. Your requests for descriptive literature, reprints, and professional trial quantities of Poythress products are cordially invited.

Representative: Hugh Mackey.

ROCHE LABORATORIES
Nutley, New Jersey

Booth 31

Continuing Roche research has produced outstanding contributions to medicine since 1909. The personnel at the exhibit welcome your comments, questions or suggestions about our products and services.

Representatives: Lacy Corbett and Luther Pratt.

J. B. ROERIG AND COMPANY
New York City

Booth 5

J. B. Roerig and Company will welcome members of the medical profession at the Company's exhibit of leading specialty products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will be pleased to discuss with you.

ROSS LABORATORIES
Columbus, Ohio

Booth 11

Similac 20, the ready-to-feed infant formula for hospitals; prediluted and presterilized in disposable glass bottles. Pediamycin (erythromycin ethyl succinate, Ross) a cherry-flavored oral antibiotic for infants and children; effective in the majority of bacterial infections, safe, easy to administer.

Representatives: Ed Rader and Don DeBona.

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Sansert, Mellaril, Cafergot P-B, Fiorinal and Fiorinal with codeine. Any of our representatives in attendance will gladly answer questions about these and other Sandoz products.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 45

New Saunders books of special interest since last year's meeting include: Dorland: Illustrated Medical Dictionary; Greenhill: Obstetrics; Curran: The Doctor as a Witness; Kelikian: The Foot; and many others.

Representative: J. P. Duncan.

E. R. SQUIBB & SONS
New York City

Booth 27

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed. At Booth 27, we will be pleased to present up-to-date information on these advances for your consideration.

STATE MEDICAL ASSOCIATION'S GROUP DISABILITY INSURANCE PROGRAM

Booth 32

The administrator of the Group Disability Insurance Program will provide a brochure describing the plan of the West Virginia State Medical Association's Group Health and Accident and Office Overhead Expense Insurance Programs to visitors at the booth. The fundamental advantage of the group insurance plan is service here in West Virginia. This is an opportunity to meet the administrator—he is the man who will pay your claim.

Representatives: J. Banks Shepherd and A. B. Daniel.

THE STUART COMPANY
Pasadena, California

Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are Dialose, Dialose Plus, Mylanta, Mylicon, Stuart Prenatal, Stuart Prenatal-F, Mulvidren-F and Mulvidren Junior.

Representative: Barry R. Smith.

THERMO-FAX SALES INC.
Wheeling, Huntington and Charleston

Booth 28

Thermo-Fax Sales Inc. will exhibit a complete line of copying machines featuring the Control-o-fax system for handling accounts receivable. This system produces a perfectly dry 3-color bond weight white statement in only four seconds. A new concept in background music from 3M Company . . . "Cantata" 700. The first quality background music system you can *own* instead of lease . . . you *own* the system . . . you *own* the music. Don't miss this new product of the 3M Company.

THE UPJOHN COMPANY
Kalamazoo, Michigan

Booth 23

Professional representatives of The Upjohn Company are eager to contribute to the success of your meeting. We are here to discuss with you products of Upjohn research that are designed to assist you in the practice of your profession. We solicit your inquiries and comments.

Representatives: Ivan Woods and Robert Gibbs.

U. S. VITAMIN & PHARMACEUTICAL CORP.
New York City

Booth 25

The U. S. Vitamin & Pharmaceutical Corporation cordially invites you to visit its exhibit where DBI & DBI-TD will be on display, as well as other leading pharmaceutical specialties and nutritional products. Professional service representatives will be in attendance to welcome you and to be of help in answering any inquiries pertaining to the products on display, as well as any of their other products.

WYETH LABORATORIES
Philadelphia, Pennsylvania

Booth 17

New Serax® (oxazepam, Wyeth) Capsules—specific for anxiety with broad clinical application. The first of a chemically new generation of compounds—the 3-hydroxybenzodiazepinones, Serax provides versatility and flexibility in control of common emotional disturbances. Also featured at the Wyeth exhibit will be three highly effective analgesics comprising the Wyeth Analgesic Spectrum of drugs, tailored to specific patient needs: Zactirin® Compound-100 (ethoheptazine citrate with aspirin, phenacetin and caffeine, Wyeth) Tablets; Equagesic® (meprobamate and ethoheptazine citrate with aspirin, Wyeth) Tablets; and Mepergan® (meperidine HC1 and promethazine HC1, Wyeth) Capsules. Full information on these products is available at Booth 17.

WARNER-CHILCOTT LABORATORIES
Morris Plains, New Jersey

Booth 47

This booth has been kindly donated by Warner-Chilcott Laboratories to provide space for an interesting scientific exhibit.

Visit the Exhibits!

Plan to spend several hours in the Exhibit Center visiting the Industrial and Scientific Exhibits. They form an integral part of the over-all program and this is your opportunity to discuss with trained professional service representatives the new products and therapeutic developments.

Pharmaceutical houses spend millions of dollars annually in medical research. The trained medical representatives who will be in attendance at the meeting are interested in disseminating information about the new drugs and advanced techniques to practicing physicians.

Please take this opportunity to visit every booth and express your appreciation to our exhibitors for their continued cooperation and support.

ANNUAL REPORTS

Cancer Committee

A meeting of the Cancer Committee was held at the Daniel Boone Hotel in Charleston on February 28, 1965, with the following members present: Dr. David B. Gray of Charleston, Dr. Hu C. Myers of Philippi, Dr. Dennis S. O'Connor and Dr. I. Ewen Taylor of Huntington, and Dr. Alvin L. Watne of Morgantown. Others present were: Dr. I. E. Buff of Charleston; Dr. Thomas W. Nale, Director of Cabell-Huntington Health Department; Mr. Harold Colley of the State Health Department; Miss Anne Rouse, Director of the Division of Cancer Control; Mrs. Frances Shaver of the State Health Department; and Mr. William Nichols, Executive Director of the American Cancer Society, West Virginia Division.

Doctor Buff reported that following a visit of Dr. Robert Horton, Chief of the Grants Division of the Air Pollution Bureau of the U. S. Public Health Service, on January 18, 1965, a study of air pollution would be made in the State and that Dr. Thomas Mancuso of the School of Public Health, University of Pittsburgh, had agreed to serve in the capacity of consultant. The Committee approved this project, subject to the approval of the Council of the West Virginia State Medical Association.

Mrs. Frances Shaver, secretary of the Central Cancer Registry, reported on the Cancer Workshop at the American College of Surgeons in Philadelphia on February 18.

It was agreed that the hospital cancer registry is of real value but only if it is used by the hospital staff. The Central Cancer Registry is only as good as the material sent from the hospital and the need for one physician in each hospital to assume leadership in that direction was emphasized. Through the Cancer Registry, an effort will be made to secure the name of such a physician in each hospital so that more definite planning can follow.

A report on the cytology projects in Cabell, Wayne and Kanawha Counties was discussed, particularly as to the establishment of more special clinics for the medically indigent women in these areas, so that future thought can be given to promotion of such screening in other areas.

Announcement was made of the appointment of Doctor Gray as a Liaison Fellow for West Virginia in the Cancer Field Program by the American College of Surgeons.

New educational material, especially concerning smoking, was shown to the committee.

The majority of the members of the Cancer Committee accepted the kind invitation of Doctor Watne to attend the dedication ceremonies for the Charleston Foundation Cancer Research Laboratory of the West Virginia School of Medicine at Morgantown on April 24.

Respectfully submitted,

Chauncey B. Wright, M. D.,
Chairman.

Huntington,
June 14, 1965.

Committee on Maternal Welfare

The meeting of the Maternal Welfare Committee of the West Virginia State Medical Association, in conjunction with the Division of Maternal and Child Health of the West Virginia State Department of Health, was called to order by the Acting Chairman at the Daniel Boone Hotel in Charleston at 11:00 A. M. on June 13, 1965.

Those present were Frederick H. Dobbs, M. D., Acting Chairman and Secretary; and the following members: Clarence H. Boso, M. D., George Gevas, M. D., Edwin J. Humphrey, M. D., Gates J. Wayburn, M. D., William G. Klingberg, M. D., and Mrs. Jeanne S. Peccianti, R. N.

The Division of Maternal and Child Health of the West Virginia State Health Department was represented by Frederick H. Dobbs, M. D., and Mrs. Jeanne S. Peccianti, R. N., Obstetric Nurse Consultant.

The Committee on Perinatal and Fetal Mortality and Morbidity was represented by William G. Klingberg, M. D., Professor and Chairman of the Department of Pediatrics at the West Virginia University School of Medicine. This Committee is still in the process of implementing a form of abstract which will be useful in the study of perinatal problems. Several pilot forms had been distributed to the larger centers of medical practice but no completed documents had been received. The present abstract is too long and detailed for the busy practitioner to complete but such a study would be of no value if there is paucity of information about each perinatal death.

The Chairman expresses his appreciation for the splendid cooperation of all members of this Committee, for without their valuable assistance in the evaluation of the abstracts and in the direction of the long-range program of this specialty, the over-all benefits derived from the work of this Committee would be markedly curtailed. The members attending the meeting represented a hard core of interested obstetricians who are professionally qualified to review the case abstracts, to understand the facts contributing to each maternal death and to make intelligent recommendations for the benefit of the interested physicians and for the edification of the physicians who practice obstetrics in the State.

The splendid cooperation of the interested physicians is appreciated and it is a source of satisfaction that a physician having a maternal death, will forward complete records, autopsies, consultations, laboratory procedures and operative records knowing that the Committee is interested in only one thing; that is, to increase the standards of obstetric practice among the physicians of this State. The data is abstracted as a hypothetical case and the name of the patient, the physician and the hospital are confidential and not available to anyone except the Secretary and his departmental secretary. In some maternal deaths a close chronological description of events, especially blood pressures, pulse and respiration is necessary to understand a sudden demise. We find that the nurse's notes, the anesthetist's record, or a resident's description of events sometimes give the clue to the cause of death. The Record Librarians have cooperated splendidly in furnishing complete duplicate copies of the hospital record. These records are treated as confidential material and kept in a locked file.

The Bureau of Vital Statistics, under the direction of Dr. N. H. Dyer and Mr. Paul Shanks, is the primary source of our maternal deaths. The death certificates of all women in the child-bearing age are checked by Miss Georgia Fry and any certificate having any relationship to childbearing is photostated and referred to the Secretary for his scrutiny. If the certificate is classified as a maternal death, the proper letters are written and a questionnaire forwarded to the physician. In borderline cases, a letter is written for clarification.

The Committee was informed by the Obstetric Consultant for the State of West Virginia that a grant from the Children's Bureau is presently being sought to provide maternity and infant care for medically indigent patients by the State Health Department in cooperation with the Kanawha-Charleston Health Department. One other such program is in full employment at the West Virginia University Medical Center under the direction of Nicholas W. Fugo, M. D., Professor and Chairman of the Department of Obstetrics and Gynecology.

After a study of the 16 abstracts of maternal deaths in West Virginia, the Committee found that several of the deaths occurred in small rural hospitals where the services of a qualified obstetrician are not available, where a blood bank does not exist, and means of obtaining whole blood in an emergency requires several hours to obtain donors, then type and cross-match the blood before matched blood is available. In these maternal deaths, the patient expired before whole blood could be started. The same recommendation for recovery rooms adjacent to the delivery area came up again because two maternal deaths were caused by patient neglect in the immediate postpartum area. The Committee has recommended again and again that each hospital practicing obstetrics in the state should provide this form of safeguard for the newly delivered patient. The ever present problem of patient neglect by the patient herself and by her family is evident in several of the maternal deaths. The patient and the families fail to recognize fatal complications which are evident at a layman's level. This is evident in toxemia, hemorrhage, premature rupture of the membranes and the development of infection.

TABULATED ANALYSIS OF COMMITTEE'S WORK

The following tables contain the tabulated analysis of the work of the Committee for the current year and these studies are submitted for the information of and study by the members of the West Virginia State Medical Association.

The latest statistical survey for West Virginia between maternal deaths and births is for 1963. In that year there were:

Total Births	35,573
Maternal Deaths	18
Maternal Death Rate	.5

MATERNAL DEATHS, JULY 1, 1964—JUNE 30, 1965

I. Classification of Maternal Deaths Reviewed by Committee During the Period of July 1, 1964—June 30, 1965

Year	*Obstetric*	*Non-Obstetric*
1964-1965	14	2* (Medical)

*1 Subarachnoid hemorrhage (postpartum); 1 glioblastoma—multi-ferme.

II. Obstetric Deaths by Cause (1964-1965)

Cause of Death	*No.*	*% of Total*
Uterine Hemorrhage	7	50.0
1—Lower Nephron Nephrosis with Placenta Previa		
1—Uncontrolled post-partum hemorrhage due to Uterine Atony		
1—Rupture of Uterus—Abdominal Hemorrhage		
1—Rupture of Uterus—Previous Section		
1—Rupture of Uterus—due to Grand Multipara		
1—Rupture of Uterus—Breech Delivery		
1—Cardiac Arrest—due to Afibrinogenemia & Acute Myelogenous Leukemia		
Cerebral Hemorrhage	2	14.3
1—Intracranial Hemorrhage due to Toxemia		
1—Cerebro-Vascular Accident (Eclampsia)		
Endotoxic Shock	3	21.4
1—Amniotic Embolism		
1—Afibrinogenemia (dead fetus)		
1—Septicemia		
Pulmonary Embolism due to Postpartum Thrombophlebitis	1	7.1
Ergotism	1	7.1
Total	14	99.9%

III. Obstetric Deaths by Preventability (1964-1965)

Classification	*No.*	*% of Total*
Preventable by Physician	6	42.9
Preventable by Patient	5	35.7
Non-Preventable	3	21.4
Total	14	100.0%

IV. Obstetric Deaths by Place of Delivery (1964-1965)

Place	*No.*	*% of Total*
Hospital	11	78.6
Undelivered	3	21.4
Total	14	100. %

V. Obstetric Deaths by Race (1964-1965)

Race	*No.*	*% of Total*
White	13	92.9
Negro	1	7.1
Total	14	100. %

VI. Obstetric Deaths by Age Groups (1964-1965)

Age Groups	*No.*	*% of Total*
15-19	2	14.3
20-24	1	7.1
25-29	3	21.4
30-34	1	7.1
35-39	5	35.7
40-44	1	7.1
44 plus	1	7.1
Total	14	100. %

VII. Obstetric Deaths by Parity (1964-1965)

Parity	*No.*	*% of Total*
Primipara	1	7.1
1-3	5	35.7
4-6	4	28.6
7 and over	3	21.4
Unknown	1	7.1
Total	14	99.9%

VIII. Obstetric Deaths by Weeks of Gestation (1964-1965)

Weeks of Gestation (Lunar Months)	*No.*	*% of Total*
Less than 28 weeks	3	21.4
28-33 weeks	1	7.1
34-39 weeks	2	14.3
40 weeks plus	8	57.1
Total	14	100. %

IX. Obstetric Deaths by Operative Procedure (1964-1965)

Procedure	Preventable	%	Non-Preventable	%
None	7	63.6	2	67. %
Cesarean Section—Classical	1	9.1		—
Low Forceps over a medio lateral episiotomy	2	18.2	1	33.
Breech Extraction—Subtotal post delivery hysterectomy	1	9.1	-	
Total	11	100. %	3	100. %

X. Obstetric Deaths by Type of Consultation (1964-1965)

Type of Consultant	*No.*	*% of Total*
Obstetrician	6	Percentages cannot be calculated because some patients were seen by more than one consultant. But it is significant that 21.4% had no consultation.
General Practitioner	2	
General Surgeon	5	
Neurosurgeon	2	
Internist	1	
Anesthetists	2	
Internal Medicine Specialist	1	
None	3	

XI. Interval Between Delivery and Death (1964-1965)

Time Interval	*No.*	*% of Total*
Under 1 day	7	50.
1 day - 1 week	3	21.4
I Week plus	1	7.1
Undelivered	3	21.4
Total	14	100. %

XII. Outcome of Pregnancy in Obstetric Deaths (1964-1965)

Type of Outcome	*No.*	*% of Total*
Livebirth—full term	6	42.8
Livebirth—premature	1	7.1
Stillbirth—term	3	21.4
Stillbirth—premature	1	7.1
Undelivered	3	21.4
Total	14	99.8%

XIII. Analysis of Obstetric Death Certificates (1964-1965)

	No.	*% of Total*
Death Certificate Correct and Complete	10	71.4
Death Certificate not Correct and Complete	4	28.6
Total	14	100. %

XIV. Autopsies done on Obstetric Deaths (1964-1965)

Autopsy Obtained	6	42.9
Autopsy not Obtained	8	57.1
Total	14	100. %

Definitions

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of the pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.
2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself, to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.
3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct result of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.
4. *Non-Related Cause of Death*—A death occuring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.
5. *Factors of Preventability (Avoidability)*—Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.
6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

Factors

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment, or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24 hour anesthesia service; (4) suitable x-ray facilities; and (5) adequate 24 hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet short-comings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

Analysis of Maternal Deaths

The Committee presents the following conclusions from the analysis of these maternal deaths.

1. Uterine Hemorrhage again heads the list accounting for seven of the sixteen obstetric deaths reported. There is an interesting variety of causes and it is in this category that the preventable factors are the most frequent. For example:

   A. *Rupture of the uterus was responsible for four maternal deaths.*

      1. A 24-year-old Gravida 6 Para 5 who had a cesarean section with the first delivery and had four vaginal deliveries following this. She was refused admission at a large urban hospital then admitted to a rural four bed clinic with the membranes ruptured and in beginning labor. Because the labor was sluggish, the physician administered a pitocin drip for two hours before delivery. The patient delivered under spinal anesthesia and immediately after the delivery of the placenta, the patient went into deep shock with nausea and vomiting from which she never did recover and she expired three hours later. There was no blood available at this clinic.

      2. A 31-year-old Gravida 4 Para 3 who had a cesarean section on the last delivery was admitted with the uterus ruptured. Eight days before this admission the patient had a second episode of vaginal bleeding and was referred to an obstetrician in a distant city because the general surgeon at this 50 bed hospital was out of the city. She refused to be referred. Upon admission with the uterus ruptured, there was no surgeon, no surgical scrub nurse and no anesthetist available for the obstetrician to come from the larger city. Instead the patient was given six pints of whole blood and put in an ambulance but she died enroute.

      3. A colored (never married) female, a Gravida 14 Para 13 with twins delivered in 1963 dropped into the hospital in active labor and after a 12 hour labor, delivered a viable fetus. An hour after delivery she went into severe shock which was treated with stimulants and dextran. A surgeon was called in consultation who did a cut-down but before the blood could be given the patient expired. She was examined and a rupture of the uterus was discovered. The patient had no prenatal care and her hemoglobin was 68% and W.B.C. 3,070,000.

      4. A white female, age 29, a Gravida 6 Para 5 was admitted in active labor with a frank breech. After a 7½ hour first stage, the cervix was completely dilated but the breech remained high. The physician felt he should interfere because of the slowing of the progress of labor, the presence of meconium stained amniotic fluid and apprehension on the part of the mother. This general practitioner attempted to hasten labor by breaking up the breech into a footling. Following delivery he discovered a cervical tear which he repaired but the patient went into profound shock with a marked loss of blood. Consultation with an obstetrician resulted in a subtotal hysterectomy under local and light anesthesia, but no rupture of the uterus was discovered. The patient expired. At autopsy the extensive posterior cervical laceration which the physician repaired extended up into a high lateral cervical laceration which was not repaired. An extensive retroperitoneal hemorrhage extended from the cervix and vaginal wall to above the upper pole of the left kidney.

   B. *Endotoxic shock accounted for three maternal deaths.*

      1. A white female age 38, a Gravida 8 Para 5 Abortus 2, was admitted at full term with the membranes ruptured seven days, and with a high fever and symptoms of puerperal sepsis. She had been admitted previously on the 9th for an induction of labor which was unsuccessful. She returned home and on the 12th the membranes ruptured spontaneously. On the 19th she was admitted with fever, sepsis and in shock. After a 3½ hour labor she delivered a stillborn fetus. Immediately following delivery the patient had a sudden chill and went into deep shock, became cyanotic, and the skin was cold and clammy. Efforts to combat this septic shock were unsuccessful and she expired 27 hours following delivery.

      2. A white female, age 28, Gravida 4, Para 2, who had no history of any prenatal care "walked in" to a hospital with her membranes ruptured for 24 hours. She was between 5 and 6 months in her fourth pregnancy and the condition of the patient upon admission was fair. Two hours after admission the patient had a severe chill, a temperature of 105 degrees F., became irrational and delirious and went into an unconscious state from which she never did recover. Seven hours later she delivered a dead fetus and died of endotoxic shock 17 hours following delivery. The placenta was retained.

      3. A white female age 16, Gravida 1, Para 0 was admitted with a temperature of 104

degrees F., which had been present for two days. She was 5½ months in this pregnancy and the physician felt that some uterine entry had been accomplished to terminate the pregnancy. She passed the fetus which lived 9 hours, but all effort to save the patient was useless because she expired 20 hours after delivery of endotoxic shock.

C. *Intracerebral hemorrhage accounted for three maternal deaths.*

1. This patient was seven weeks in the postpartum area when she was admitted with the symptoms of subarachnoid hemorrhage. This was verified by multiple trephination and evacuation of a left frontal intracerebral hematoma. The patient gradually deteriorated and expired on the 6th hospital day.
2. A white female age 39, a Gravida, Para 3 was carried into the emergency room of the hospital in a comatose state. She was 8½ months in her 9th pregnancy and gave a history of being found by her husband unconscious on the floor at home. In spite of stimulants, the patient expired in 3 hours.
3. This 19 year old primigravida was admitted to the hospital at full term with a blood pressure of 118/68. She had preeclampsia for the last 3 months of her pregnancy with an average blood pressure of 170/90. After three hours of labor the patient became disoriented, restless and crying out with pain. The blood pressure was 240/130, the pupils dilated and fixed with no patient response to questions or stimulus. The patient suddenly became critical and went into a deep coma and expired 29 hours after delivery. She had bloody spinal fluid and all the symptoms of a cerebral vascular accident.

D. *Hemorrhage accounted for seven maternal deaths including the three listed below plus the four cases of ruptured uterus.*

1. This white female, age 43, a Gravida 9, Para 6, Abortus 2, was admitted to the hospital with painless, ceaseless vaginal bleeding and and in acute shock with the pulse weak and thready, a blood pressure of 70/50 and the skin pale, cold and clammy. The fetus had expired in utero and an effort to save the mother was made by performing an immediate cesarean section and giving 8 pints of whole blood. In spite of the heroic measures, the patient developed a lower nephron nephrosis and expired 5 days after delivery.
2. A white female, age 36, a Gravida 10, Para 9 was admitted in active labor and delivered a stillborn full term pregnancy. Following the delivery of the placenta, the patient continued to bleed and the diagnosis of uterine atony the result of placenta ablatio was made. The patient was not packed, was not given blood and a hysterectomy was not done. She expired 12 hours after delivery of the placenta.
3. A 39 year old white female, a Gravida 2 Para 1 was admitted at full term in active labor. Following the delivery of a viable fetus, and delivery of the placenta, the patient developed a blood clotting defect with blood oozing from the suture holes in the episiotomy and it was noted that the blood in the floor basin was not clotting. Twenty-one minutes after delivery the patient went into cardiac arrest and expired in 30 minutes. The autopsy revealed afibrinogenemia and acute myelogenous leukemia.

E. *The indirect obstetric cause of death in this maternal death was brain tumor.*

1. A white female, age 31, a Gravida 2, Para 1, was admitted to the hospital in an effort to prolong her life enough to allow her pregnancy to grow to viability. At 8 months in the pregnancy, a cesarean section was performed with the delivery of a viable fetus. The patient had previous brain surgery with the removal of a glioblastoma multiforme and received x-ray therapy over the area. She then became pregnant and with the return of the tumor growth the pregnancy became threatened. She died 44 days after cesarean section.

F. *Postpartum pulmonary embolism accounted for one maternal death.*

1. This white female, age 29, a Gravida 3, Para 2 was admitted to the hospital three weeks overdue in the present pregnancy. She delivered uneventfully and returned home. A week after discharge, she developed pain in the left calf and after examination the diagnosis of thrombo-phlebitis was made. She was finally admitted 12 days after her discharge and was started on parenzyme, orenzyme, penicillin and bed rest. She made a remarkable recovery in 5 days but she suddenly developed tonic and clonic convulsions and expired in an hour.

G. *Ergotism accounted for a single maternal death.*

1. A white female, age 45, whose obstetrical status is not known, was admitted to the hospital with the symptoms of ergotism. The patient was divorced and denied pregnancy, but the attending physician had a positive pregnancy test. As the poison spread over the patient's body, she developed cyanosis of the lower extremities, generalized weakness and hyporeflexia. The cyanosis gradually spread up to the knees, the hyporeflexia progressed to complete paralysis, she became completely unable to swallow and gradually went into a deep coma and expired 36 hours after hospital admission.

Respectfully submitted,

A. J. Villani, M. D.,
Chairman,
F. H. Dobbs, M. D.,
Secretary

Charleston
June 17, 1965.

Committee on Medical Scholarships

The Committee on Medical Scholarships met in Morgantown on April 23-24 for the primary purpose of interviewing applicants for medical scholarships and selecting the two recipients. The meeting was attended by Dr. J. P. McMullen of Wellsburg, Chairman; and Drs. Thomas J. Holbrook of Huntington, Russel Kessel of Charleston, John Mark Moore of Wheeling and Clark K. Sleeth of Morgantown. The meeting also was attended by Dr. Seigle W. Parks of Charleston, President Elect of the West Virginia State Medical Association, and William H. Lively of Charleston, Executive Secretary.

The Committee interviewed 13 applicants for the two 1965 scholarship awards. Selected as recipients were Creel S. Cornwell, Jr., of Lost Creek, and Wil-

liam L. Mossburg of Morgantown. Alternates are Lawrence W. Shivetaker of Nitro and Robert C. Nerhood of Charles Town.

The Committee unanimously directed that $4,000 be made available during the 1965-66 school year to the West Virginia University School of Medicine for use as an emergency loan fund for students. The money is to be placed in the Charles Lively Memorial Scholarship and Loan Fund of the West Virginia University Foundation.

Respectfully submitted,

J. P. McMullen, M. D.,
Chairman.

Wellsburg,
June 16, 1965.

Medical Aspects of Sports

The Committee on Medical Aspects of Sports has had as its project this year pre-seasoning conditioning for football. We advocated having a one to two week period of conditioning for this sport.

This was first passed by the Committee in the Spring of 1964. The West Virginia Coaches Association approved it in the Summer of 1964 and then forwarded it to the West Virginia Secondary School Activities Commission. In the Spring of 1965 the Coaches Association formally approved it at a meeting in Charleston. It was presented in April to the West Virginia Secondary School Principals Association, which approved it. It was the feeling of the Committee that this would lessen the injuries and in retrospect help the insurance program.

The Chairman appointed Dr. Henry R. Glass, Jr., of Charleston as the director of the Sports Injury Clinic conducted in conjunction with the West Virginia Coaches Association meeting in Charleston on Saturday, March 23, 1965. We obtained as a guest speaker Dr. Thomas E. Shaffer, team physician of Ohio State University and a member of the AMA Medical Aspects of Sports Committee. He gave a fine presentation of the adolescent athlete. The Committee was then asked to conduct another conference in conjunction with the meeting of the West Virginia State Coaches Association on May 22. At this time Whitey Gwynn, Trainer at West Virginia University, was asked to give a session on bandaging and wrapping. This was followed by a discussion of the pre-season conditioning, at which time Dr. William E. Gilmore of Parkersburg presented an interesting talk on "The Athlete and Climatic Conditions," which was well received.

The Committee Chairman attended the AMA Medical Aspects of Sports meeting in Miami in December and our Committee was commended on its progressive work in the care of the athlete. We have also had expressions of thanks from both the coaches of the State and the Secondary Schools Activities Commission.

Respectfully submitted,

Richard W. Corbitt, M. D.,
Chairman.

Parkersburg,
June 8, 1965.

Medical Education and Hospitals

A meeting of the Committee on Medical Education and Hospitals was held at The Daniel Boone Hotel in Charleston on April 11, 1965. Committee members in attendance were Dr. Pat A. Tuckwiller of Charleston, Chairman; and Drs. Richard Hamilton of St. Marys, Richard V. Lynch, Jr., of Clarksburg, Thomas G. Reed of Charleston and Clark K. Sleeth of Morgantown.

Other persons attending the meeting included: Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association; Dr. Daniel Hamaty, Director of Medical Education at Charleston Memorial Hospital; Dr. George M. Kellas, Director of Medical Education at Wheeling Hospital; Mr. William Byrd, Coordinator of Mental Health Education for the West Virginia Department of Mental Health; and Mr. William H. Lively, Executive Secretary, and Mr. Edward D. Hagan, Executive Assistant of the State Medical Association.

Mr. Byrd said the Department of Mental Health is anxious to collaborate with the State Medical Association, the WVU Medical Center and other organizations to provide postgraduate education for physicians in the field of mental health. He said the Department realizes that general practitioners and non-psychiatric physicians by necessity play a major role in dealing with mental health problems.

Mr. Byrd expressed the hope that the Department will be able to obtain a grant from the National Institutes of Mental Health to finance postgraduate programs.

Doctor Hamaty discussed in detail a proposed medical education workshop for West Virginia. He said the purpose would be to discuss problems related to undergraduate, intern and resident, postgraduate and continuing medical education programs.

It was recommended that the West Virginia University School of Medicine, in cooperation with local medical societies and hospital staffs, should take the lead in presenting educational symposia in the State. Doctor Sleeth, Dean of the WVU School of Medicine, said there is a possibility that teams of faculty members will be organized to participate in symposia arranged throughout the State.

The Committee spent considerable time discussing intern and residency training programs in hospitals in the State. It was pointed out that 21 of the 57 students scheduled to receive M. D. degrees in June from the School of Medicine will intern in West Virginia hospitals. Doctor Sleeth said several students who have accepted internships elsewhere stated they plan to return to West Virginia upon completion of their training.

Also discussed at length was the nature and quality of scientific programs presented at meetings of county medical societies. It was recommended that the headquarters offices serve as an information center to disseminate data to local medical societies concerning speakers or groups of speakers who have presented interesting programs before a local society. Doctors Lynch and Sleeth were named to a subcommittee that will draft an evaluation form. This would provide a means of evaluating speakers who have presented

programs before a local society. Local secretaries would be asked to complete the forms and mail them to the headquarters offices, where they would be duplicated and mailed to secretaries of other component societies.

The Committee also discussed the great number of conflicting dates of medical meetings scheduled during the year. It was pointed out that it has been difficult to schedule meetings on dates satisfactory to all participants. The Executive Secretary was directed to contact medical and allied organizations for the purpose of determining dates for meetings as far in advance as possible. The meeting dates will be published in *The West Virginia Medical Journal* each month.

The Committee will meet again on July 18, which will enable the Chairman to make an additional report, if necessary, before the Council of the West Virginia State Medical Association during the 98th Annual Meeting in White Sulphur Springs in August.

Respectfully submitted,

Pat A. Tuckwiller, M.D.,
Chairman.

Charleston,
June 3, 1965.

Medical Economics Committee

The special study sub-committee of the Medical Economics Committee, under the chairmanship of Dr. Kenneth G. MacDonald, is in the final stages of preparing the schedule of relative value units to be published as the West Virginia Relative Value Index. The schedule should be ready for final approval at the annual meeting in White Sulphur Springs prior to publication.

It should be emphasized at this time that this is a relative value index which is published as a help to the private physician in arriving at a fee for service. It is in no way published as a means of controlling the fee for service rendered. Each physician using the index as a guide applies his own conversion factor in determining his fee for service. It must be understood that the relative value units are set by the physicians in general practice and in the other individual specialties.

It is suggested that the schedule initially be prepared in loose leaf form and be subject to alteration by a review and acceptance of such change by these individual groups. The relative value index, however, may well serve as a guide in determining the fee for service where third party service coverage is concerned. Under these circumstances the individual relative value of each procedure is first under the direct control of the physician and the conversion factor for service policies written for either local, state or federal insurance programs would be negotiated by the appropriate committee of the state or individual county medical society.

The remaining sub-committees of the Medical Economics Committee are concerned with third party agencies: (1) Blue Shield, (2) Medicare (ODMC), (3) Workmen's Compensation Fund, (4) Veterans Administration, and (5) Department of Welfare.

The Blue Shield sub-committee has spent its major effort in attempting to develop a Blue Cross-Blue Shield Plan—The Blue Plan—which would have been used in a more comprehensive medical care program for the Department of Welfare. Such a plan was presented to the Department of Welfare and to the Joint Committee on Government and Finance of the West Virginia Legislature. A bill which failed to get through the Legislature was submitted which would have authorized the Department to utilize such a plan.

The National Association of Blue Shield Plans is interested in either combining the Blue Shield plans in West Virginia or at least standardizing the many facets of the service and indemnity policies, i.e.:

(1) The coverage of policies.
(2) The maximum annual income or maximum average income for which service policies may be written.
(3) Fee for service.

The National Association of Blue Shield Plans is obviously interested in this because of the problems of negotiating national contracts involving both service and indemnity programs. We all recognize the values but also the potential hazards of such programs particularly where the physicians do not have control over the coverage, income or fee for service. Even if in the individual service areas of the many Blue Shield Plans, the physicians have this control and are satisfied with all details, we must realize that the decisions made by these physicians on the boards of the local Blue Shield plans directly affects all of the other Blue Shield plans, as well as directly affecting negotiations in all third party medical care programs involving all physicians in the State.

Negotiations over the past few years with Medicare (ODMC) now have progressed to the point where we are requesting that agency to publish a fee schedule for an average annual income of recipients of service in West Virginia based on the service policies in West Virginia Blue Shield plans, with income maximums the same or slightly higher. During the coming year this schedule must be carefully reviewed and the policy of its development considered. Since the Medicare schedule has been changed by the federal government to a fixed fee rather than usual fee for service with an unpublished maximum—at least each physician should have an opportunity to review the schedule and decide for himself if he wishes to participate in this program. I would suggest that a poll of our members be conducted after they have had an opportunity to study the schedule for a period of six weeks. Such information would then serve to guide us in negotiating a contract for next year.

Negotiations on fees for service are now being carried out between representatives of the West Virginia State Medical Association and the Workmen's Compensation Fund—Dr. Kenneth G. MacDonald and Dr. Henry M. Hills, Jr., for the Association, and Mr. Ronald Payne, Mr. E. L. Wiley and Mr. John Farley for the Compensation Fund. Every attempt is being made to

establish fees for service utilizing the relative value indexes to be published as the base and applying conversion factors stipulated by the various medical and surgical specialty sections of the State Medical Association. These negotiations are complicated considerably by the precedents established by the many Blue Shield Plans in this state. It is difficult to argue a fee for service higher than the lowest fee in a service policy and certainly not higher than the highest fee paid, covering a *maximum annual income group similar* to the *average annual income* of patients covered under the Compensation Fund, no matter how inadequate it may be.

The fallacies in the application of fees for service in Blue Shield service policies to average annual income is evident, but difficult to explain to agencies who are looking for lower fees and clients looking for lower premiums. The differentiation must be adhered to if we are to have peace in the medical community in West Virginia. It is my belief that fees for service in average annual income group coverage must be well above the fee in service policies based on a maximum annual income, if in fact such a policy should ever be accepted. Certainly here the medical community could ethically draw the line.

A compensation bill to be introduced during the next regular session of the Legislature must be developed with the cooperation of both labor and management for the purpose of updating the compensation laws of West Virginia. Further need is evident in updating the rules and regulations pertaining to hospital, physicians and dentists services rendered to recipients of service under the compensation regulations.

The Veterans Administration has developed a new fee for service to veterans. Since we still have not developed the West Virginia Relative Value Schedule, the California Relative Value Schedule is being used. Usual fees for service were obtained for selected procedures from the major cities of West Virginia. These were averaged and a conversion factor thus was determined to apply to the California Schedule in order to publish the Veterans Administration fee schedule for West Virginia. We are currently reviewing this proposed fee schedule and, again, I would suggest as in the Medicare fee schedule that after six months of review by physicians that a poll be conducted. Such information would then guide us in negotiating a contract for next year.

The physician members of the Joint Conference Committee have continued to request the Department of Welfare to increase the fees for services rendered up to at least the average reimbursable cost. National and state estimates place this at between 40 and 50 per cent of the usual fees for service. The committee also has continued to place emphasis on a request for an extension of service to recipients to include the aspects of prevention and rehabilitation.

Respectfully submitted,

George R. Callender, Jr., M. D.,
Chairman.

Charleston,
June 25, 1965.

Mental Health Committee

During the year 1964-65, the Committee on Mental Health was fairly active in mental health affairs throughout the State. Almost every member on the Committee served in some capacity on the survey conducted by the Department of Mental Health and served mostly in advisory roles to the various sub-committees of this survey. The members of the Committee also participated in the statewide conference held to outline plans for the development of a program arising from this survey.

Among other things, the members of the Committee were instrumental in helping to frame a questionnaire which was sent to all physicians in the State of West Virginia regarding current mental health services. From this questionnaire, the Chairman of the Committee and members from the Department of Mental Health were able to conclude a brief report which will serve as a guideline for the mental health programs which are now in the process of being developed.

Another highlight of the year's activities was the attendance of the special meeting of the APA in Washington on the proposals for the spending of mental health money toward the development of community health centers. At the present time, the State Mental Health Department is actively participating in the development of a community health center in Charleston.

The other members of the Committee on Mental Health are Drs. Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Roy A. Edwards, Jr., and R. W. Hibbard, Huntington; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; A. L. Wanner and Stephen D. Ward, Wheeling; David M. Wayne, Bluefield; William E. Wilkinson, Beckley; and A. C. Woofter, Parkersburg.

Respectfully submitted,

William B. Rossman, M. D.,
Chairman.

Charleston,
June 29, 1965.

WVU Medical Center
—News—

DR. Paul A. Miller, President of West Virginia University, recently announced four new appointments to staff positions at the School of Medicine.

They are: Dr. Allen L. Morehart, Assistant Professor of Microbiology; Dr. James D. Martin, Assistant Professor of Neurology; Dr. Wilma Reinheimer, Research Fellow in the Division of Internal Medicine; and Dr. Gwendolyn R. Hogan, Assistant Professor of Neurology and Pediatrics.

Doctor Morehart, a native of Williamsport, Pennsylvania, received his Ph.D. degree in 1964 from the University of Delaware. He has been a research associate at the University of Oklahoma.

A native of Cullman, Alabama, Doctor Martin received his M.D. degree in 1959 from Vanderbilt University and has been a research fellow at the Harvard Medical School.

Doctor Reinheimer has been participating in a research fellows program in his native Germany.

Before joining the WVU staff, Doctor Hogan was Assistant in Neurology at Harvard University. She received her M.D. degree in 1957 from the University of Virginia School of Medicine. Doctor Hogan is a native of Charlottesville, Virginia.

Faculty Members Travel Abroad

Three members of the faculty of the School of Medicine's Department of Microanatomy and Organology are participating in meetings in Germany this month.

Drs. A. C. Higginbotham and Randall W. Reyer, Associate Professors, and Mrs. Frances Higginbotham, Research Associate, will attend the Eighth International Congress of Anatomists in Weisbaden, August 8-13.

Doctor Higginbotham will present a demonstration on "The Vascular Architecture of Dog and Monkey Vasa Vasorum Visualized in Three Dimensions." This was co-authored by Dr. T. Walley Williams, Chairman of Microanatomy and Organology, and David A. Santrock, a medical student.

Mrs. Higginbotham will present a paper, co-authored by Doctor Higginbotham, entitled "Histochemical and Morphological Changes in Experimental Canine Atherosclerosis."

New Residents and Interns

Nineteen young physicians began their residency training programs at West Virginia University Hospital on July 1.

• **Compiled from materiol furnished by Arthur V. Ciervo, Director, Medical Center News ond Informotion Services, Morgantown, West Virginio.**

The residents, their hometowns and medical schools are as follows:

Medicine, Thomas Dotson of Summersville (West Virginia University); Dominic Gaziano of Pemberton (University of Virginia); Susan Gustke of Chester (WVU) and Nam Paik of Seoul, Korea (Seoul University).

Neurology, Gerald F. Ronning of Minneapolis (University of Minnesota); Obstetrics and Gynecology, Scott W. Bowie of Morgantown (WVU); Pathology, Wha Young Bahn of Seoul (Soo Do Medical College); Pediatrics, Tsu-Chun Lin, Taiwan, China (National Taiwan University).

Anesthesiology, William Morrison of Terra Alta (WVU); General Surgery, Robert F. Beller of Washington (Georgetown University); Jorge Cueto of Mexico (Military Medical School); Fulvio R. Franyutti of Jaltipan, Mexico (University of Mexico); Siroos Gerami of Abeh, Iran (Pahlavi University); Jay M. Hoppenstein of Dallas, Texas (Texas Southwest Medical School); Claude S. Poliakoff of Brussels, Belgium (Columbia College of Physicians and Surgeons); James E. Demules of Minneapolis (Minnesota); and Benjamin L. Plybon of Huntington (WVU).

Neurosurgery, Alfredo C. Carrion of Buenos Aires, Argentina; and Otolaryngology, George W. Jaquiss of Ashland, Kansas (University of Kansas).

New interns are: Charles R. Baisden, Morgantown (WVU); John W. Brady, Jr., Silver Spring, Md. (George Washington); Victor T. Bazzone, Pittsburgh (University of Pittsburgh); Garret H. Conner, Rockville, Md. (George Washington); James Dollison, Fairmont (WVU); Ivan R. Harwood, Jr., Huntington (WVU); Douglas J. Holmen, White Bear Lake, Minn. (Minnesota).

Alec L. Janes, Minneapolis (Minnesota); Jerome G. Johnson, International Falls, Minn. (Minnesota); Robert P. Kalivoda, Niagara Falls, N. Y. (WVU); Thomas R. Reagan, St. Paul, Minn. (Minnesota); Wallace A. Rogers, Jr., Fort Dodge, Iowa (Minnesota); Stephen E. Sochren, Charles City, Iowa (University of Iowa); John A. Soucheray, St. Paul, Minn. (Minnesota); William C. Stewart II, Charleston (WVU); Raymond B. Weiss, Minneapolis (Minnesota); and Sharon Woods, Mullens (WVU).

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Public Health Services Advisory Committee on Immunization Practices has predicted increased amounts of influenza in the coming season (1965-66). The committee again recommended immunization for persons in groups who experience high mortality from epidemic influenza. Vaccination, the committee said, should begin about September 1, and ideally be completed by mid-December.

"It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before the development of anti-bodies," the committee said.

Groups for which annual immunization were recommended:

"(a) Persons at all ages who suffer from chronic debilitating disease, e.g., chronic and cardiovascular, pulmonary, renal or metabolic disorders; in particular;

"1. Patients with rheumatic heart disease, especially those with mitral stenosis.

"2. Patients with other cardiovascular disorders such as arteriosclerotic heart disease and hypertension, especially those with evidence of frank or incipient cardiac insufficiency.

"3. Patients with chronic bronchopulmonary disease, for example, chronic asthma, chronic bronchiectasis, pulmonary fibrosis, pulmonary emphysema, pulmonary tuberculosis.

"4. Patients with diabetes mellitus and Addison's disease.

"(b) Persons in older age groups.

"(c) Pregnant women.

"(d) Patients residing in Nursing Homes, Chronic Disease Hospitals, and other such environments should be considered as particular risks since their more crowded living arrangements may allow for greater spread of disease once an outbreak has been established."

The committee reported that there were cases of influenza in a majority of the states in the eastern two-thirds of the country during last season (1964-65) but that the amount of the disease in the United States as a whole was limited. There was no major epidemic anywhere in the country and most states in the far west were unaffected.

The committee said that Type A influenza viruses may predominate in 1965-66 but that Type B outbreaks also could be expected.

As to vaccine efficacy, the committee said:

"Influenza vaccine has consistently shown a substantial protective value when the viruses incorporated in the vaccine were antigenically similar to those causing the epidemic disease. Exceptions to the vaccines' apparent effectiveness have occurred in instances when the prevalent virus underwent a major antigenic shift after vaccines had been formulated. Careful study goes into the annual design and updating of the composition of influenza vaccines. The final selection of components reflects the best judgment regarding a potent, contemporary vaccine.

"That influenza vaccine prevents mortality from influenza, particularly among the aged and chronically ill, is based upon inference. It is presumed that vaccine protection demonstrated in studies among younger persons is similar among the aged and chronically ill, the group at particular risk of death should they acquire the disease. It is further assumed that such protection against clinical disease serves to protect them also against mortality associated with epidemic influenza."

'Pep Pill' Legislation

Congress has approved legislation imposing stiff Federal controls on the manufacture and sale of amphetamine and barbiturate tablets.

The American Medical Association supported the legislation which was aimed at curtailing use of the drugs as "pep pills" and "goof balls."

In requesting the legislation Food and Drug Administration Commissioner George P. Larrick told Congress that half of the nine billion amphetamines and barbiturates manufactured annually have been sold on the black market to teen-agers, truck drivers and persons searching for a substitute for marijuana, heroin or cocaine.

The version of the legislation as finally approved left it up to the Secretary of Health, Education and Welfare whether he utilizes an advisory committee before deciding whether depressant or stimulant drugs have a bad effect on a person's personality. The AMA had recommended that this provision be mandatory.

The new law also requires detailed bookkeeping on the drugs by manufacturers and wholesalers. Druggists' sales records of the pills must be open for inspection by FDA agents. This provision aimed at keeping track of the retail distribution of the prescription drug.

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DOSAGE: Children—six years or over—One teaspoonful three times daily for 3 days.

CAUTION: Drowsiness may occur. Use only with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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Obituaries

BENJAMIN VANCE BLAGG, M. D.

Dr. Benjamin V. Blagg, 74, of South Charleston, died July 9 in a Charleston hospital.

A native of Capehart, Mason County, Doctor Blagg had practiced medicine in South Charleston since 1917. He received his M. D. degree in 1917 from Eclectic Medical College in Cincinnati.

He also attended Marshall University and did postgraduate medical work at the New York Postgraduate Hospital and the Cleveland Clinic.

He was an honorary member of the Kanawha Medical Society and the West Virginia State and American Medical Associations.

Survivors include two sons, Dr. John S. of South Charleston and B. V. of Washington; a daughter, Mrs. Lisa Jeanne Burlingame of Charleston; the mother, Mrs. Luemma S. Blagg of Pt. Pleasant; brothers Donald O. of St. Albans and Okey C. of Point Pleasant; and two sisters, Mrs. Bleva Smith of Point Pleasant and Mrs. Eula Scholl of Cincinnati.

* * * *

ROBERT WOOD DAILEY, M. D.

Dr. Robert W. Dailey, 81, died at his home in Romney on June 2 after a long illness.

A native of Romney, Doctor Dailey had been a practicing physician for 45 years. He was a graduate of Potomac Valley Academy and received his M. D. degree from the Loyola University School of Medicine in Chicago in 1916.

Doctor Dailey was an honorary member of the Potomac Valley Medical Society, the West Virginia State Medical Association and the American Medical Association.

His wife, Nancy Curtis Dailey, preceded him in death.

Survivors include a son, Robert W. Dailey, Jr.; a daughter, Miss Frances C. Dailey of Romney; and three sisters, Mrs. James K. Guthrie and Miss Rebecca H. Dailey of Martinsburg, and Mrs. Lawrence Walker of Spartanburg, South Carolina.

* * * *

WILLIAM JOSEPH HRUTKAY, M. D.

Dr. William J. Hrutkay, 64, of Bradford, Ohio, formerly of Logan County, died on June 14 in a hospital in Cleveland.

Doctor Hrutkay, a native of Pittsburgh, attended St. Louis University and received his M.D. degree in 1927 from the St. Louis University School of Medicine.

He was company physician for Amherst Coal Company in Logan County from 1950 until his retirement in 1962. He was a former member of the Logan County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the mother, Mrs. Justina Hrutkay, and one sister, Mrs. John J. Bacik, both of Cleveland.

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M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
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County Societies

CABELL

Mr. Raymond Brewster, a Huntington newspaper executive, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick on June 10.

Mr. Brewster, Vice President and Editor-In-Chief of the company that publishes Huntington's daily newspapers, spoke on "Medicine in the News." He said there is an increasing understanding of medicine by the press and asserted: "Medicare is a long stride toward socialism."

Dr. Walter R. Wilkinson, the President, presided at the meeting which was attended by 54 members and guests.—Harold N. Kagan, M. D., Secretary.

* * * *

RALEIGH

Dr. William A. Benfield, Jr., Senior Minister of the First Presbyterian Church in Charleston, was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held in Beckley on June 17.

Doctor Benfield spoke on "The Relation of Theology to Medicine." Dr. Warren D. Elliott, President of the Raleigh Society, presided at the meeting.

Drug Reactions—Experiments of Nature

One should consider stopping all drugs whenever doubt arises about the relationship of an unexpected clinical course to the drugs being given. Only rarely is the situation so urgent that stopping treatment might be riskier than continuing it.

Each drug reaction is an experiment set up by nature. The discerning clinician can make use of adversity by planning appropriate studies to elucidate the mechanism of the reaction.

Indeed the mimicking of diseases by drug reactions (systemic lupus erythematosus following hydralazine, mental depression following reserpine, Parkinson's syndrome following phenothiazine derivatives, and others) often provides new and valuable hypotheses about the causes of these diseases.—Leo E. Hollister, M. D., in Postgraduate Medicine.

The brain is a part of the human mechanism that begins to function at birth and stops when its owner gets up to make an impromptu speech.—The New Physician.

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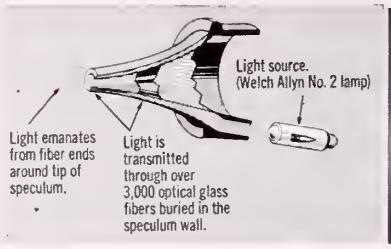

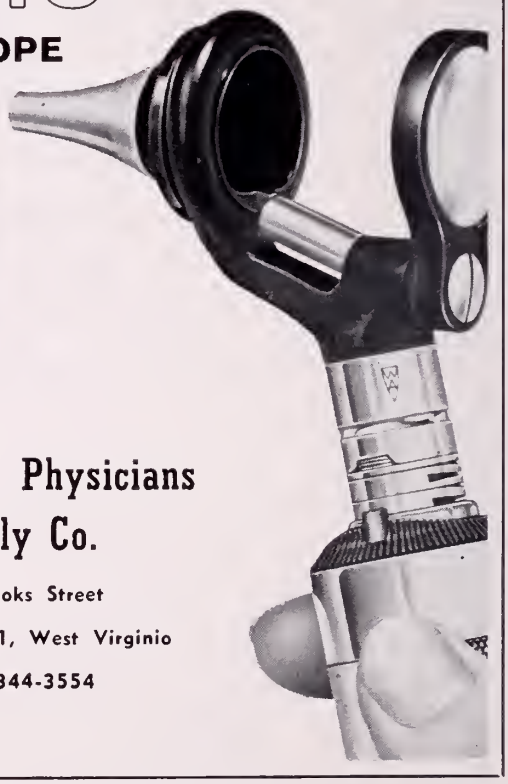

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There is general agreement that milder cases of osteoarthritis are preferably treated by simple analgesics. In many patients, however, this mode of therapy fails to give sufficient relief. Because steroids are not very effective in this form of arthritis, phenylbutazone affords the drug therapy most capable of relieving the more severe cases. For best results, it is recommended that treatment with phenylbutazone be combined with physiotherapy and other appropriate supportive measures.

Dosage
The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

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Book Reviews

RHEUMATIC FEVER, DIAGNOSIS, MANAGEMENT AND PREVENTION—By Milton Markowitz, A. B., M. D., Assistant Pediatrician-in-Chief, Sinai Hospital of Baltimore; Associate Professor of Pediatrics, Johns Hopkins University School of Medicine; and Ann Gayler Kuttner, B. S., Ph.D., M. D., Associate Professor of Pediatrics, Emeritus, New York University, Bellevue Medical Center; W. B. Saunders Company, Philadelphia and London. 1965. Pp. 242 with illustrations. Price: $7.50.

This monograph covers every aspect of one of the most important diseases seen by the pediatrician, internist and general practitioner. During World War II almost 100,000 men were ineligible for military service because of rheumatic heart disease.

The authors have discussed at length the role of the streptococcus and offer several interesting theories as to the mechanism by which it precipitates the disease. The reader will find much practical help in the diagnosis and management of this disease and he will also find the theory and studies which have established these precepts.

The physician in practice may find many facts which he has suspected but has not known for certain; for example, the prognosis is better in patients with severe polyarthritis as the incidence of carditis is less. An excellent chapter deals with the differential diagnosis and the errors commonly made. While they describe all the recent tests which help one diagnose rheumatic fever and discuss the various criteria by which a diagnosis is made, the authors also point out the pitfalls and the seriousness of over-diagnosis.

One might be surprised to learn that the authors find no clear evidence that cardiac damage is prevented or minimized by salicylates or steroids regardless of the time used or their dosage. Some physicians routinely give penicillin for several days after exposure to streptococcal disease. This practice, the authors point out, can be potentially dangerous since the overt infections might be suppressed but the organism not eradicated.

The authors emphasize the need for adequate treatment in order to prevent initial attacks and recurrences following streptococcal infections. The various methods of prevention of second attacks are considered and the many questions of who should be treated and for how long, etc, are answered.

This book should be a most valuable addition to the library of those who see acutely ill children and adults. The authors are foremost authorities and their wide experience with rheumatic fever has enabled them to write a book by which we can share in their vast knowledge of a strange and difficult disease.—Robert D. Crooks, M. D.

In time and as one comes to benefit from experience, one learns that things will turn out neither as well as one hoped nor as badly as one feared.—Jerome S. Bruner.

The West Virginia Medical Journal

September, 1965 Vol. 61, No. 9

Should the Ovary Be Conserved at Hysterectomy?

Nicholas W. Fugo, Ph.D., M. D.

For the past decade there has been a great deal of controversy as to whether the gonads should be conserved during hysterectomy. Many physicians feel that ovarian tissue should not be removed unless diseased. The opinion is expressed that at the time of hysterectomy the gonads should remain intact regardless of the age of the patient.

There is no question regarding the fact that ovarian conservation is important in the female of the reproductive age. Too often laparotomy is performed on young women, with partial or complete removal of an ovary without regard for the nature of the ovarian neoplasm. There are, during the reproductive years, many ovarian enlargements which are physiological and which tend to disappear spontaneously without surgical intervention.

This discussion will be confined to those women who are in need of hysterectomy for definite abnormalities of the uterus, tubes or cervix and who are at or past the climacterium. It is my conviction that during this period of life when the uterus no longer has a known function, the ovaries should be removed along with the uterus in the best interest of the patient.

This conclusion has not been arrived at without serious consideration of all factors relating to the possible beneficial effects of leaving gonads behind in the premenopausal or postmenopausal woman. Most gynecologists and surgeons, being men, think subjectively about the prospect of castration. But the gonads of the two sexes, while having a similar embryological origin, vary widely in their functional capacities in adult life.

Male and Female Gonads Differ

Let us examine the differences between the male and female gonad. Gamete production in the female lasts for 30 to 35 years, beginning one or two years after the menarche and ending at the age of 47 or 48 with the cessation of menses. In the male, however, germ cells are produced in many individuals from puberty until death. Sex hormone production lasts only 30 to 35 years in the female, with its onset before the menarche and its end for all practical purposes with the menopause. In the male, however, adequate titers of hormones continue throughout life. The incidence of gonadal carcinoma in the two sexes is the same (1-100). Examination of the male gonad, however, is much easier than that of the female which is not so available for palpation and thorough examination.

Several practical advantages accrue in the removal of the ovaries in women of this age group. Removal of the adnexa results in easier peritonealization of the pelvis at the time of surgery. Furthermore, it eliminates the danger of ovarian carcinoma. The possibility of interference with the ovarian blood supply resulting from uterine surgery is real and may produce cystic changes which necessitate further surgical procedures. Gonads which are allowed to remain in the pelvis after hysterectomy may be a source of pain on coitus.

Some physicians feel that there are disadvantages in removal of the adnexa. One of these is the need for replacement therapy. The belief exists that the ovaries produced estrogens indefinitely. It has been reported that during the

The Author

- **Nicholas W. Fugo, M. D., Professor and Chairman of the Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Morgantown.**

Submitted to the Publication Committee, January 20, 1965.

active reproductive period of a woman's life between 220 and 320 micrograms of estrogens are found per 24 hours. In the postmenopausal period 50 micrograms per 24 hours are excreted. This is insufficient estrogen based on clinical observation to maintain the normal physiology of the human female. With bilateral oophorectomy 40 micrograms are excreted per 24 hours and when adrenalectomy is associated with oophorectomy only 10 micrograms are measured per 24 hours. This suggests that in the postmenopausal woman the major source of estrogens is the adrenal and that the ovary contributes only a small portion of the circulating hormone.

The increased life expectancy of women today also must be taken into consideration. At the beginning of the present century the life expectancy was 48 years which is the average age for cessation of estrogen production. Today women are living beyond 75 years of age. Consequently, the need for estrogens extends for 25 years beyond the physiologic menopause.

Some Sequelae of Estrogen Deficiency

There are a number of sequelae that occur as a result of estrogen deficiencies. Negative nitrogen balance occurs since estrogens are essential for anabolism and nitrogen retention. Hypercholesterinemia also develops. This is reflected in the fact that coronary atherosclerosis is 10 to 40 times more common in young men than in young women of the same age group. When you compare the sexes after the age of 50, however, the incidence is the same.

It has been definitely shown that estrogens lower cholesterol levels in the blood stream. Estrogen lack in the female also contributes to hypertension. The incidence of hypertension in men and women per 1000 population under the age of 25 is 20. Between the ages of 45 and 54 there are 30 males with hypertension to 70 females. After age 55, the incidence of the disease in both sexes per 1000 population is 70 for males, 180 for females.

Estrogen deficiency results in osteoporosis. The condition is encountered in varying degree in all women over 50. It has been demonstrated that estrogens increase osteoblastic activity. Consequently, estrogen deficiency results in excessive destruction of bone with resultant loss of height, dorsal kyphosis and that common complaint of women: low back pain.

There are a number of other serious defects which are directly the result of estrogen lack. These are characteristic and can be observed in any woman who has passed the menopause. The breasts become flabby, the vagina loses its distensibility and becomes thin-walled and atrophic. Consequently, it becomes susceptible to infection; the development of senile vaginitis and its concomitant symptom, pruritis, is common. There also may be the problem of urinary incontinence as the result of atrophy of the muscles and connective tissues supporting the bladder.

Ovarian Carcinoma

Ovarian carcinoma is an important consideration when the ovaries are allowed to remain after hysterectomy in climacteric women. Of 1000 women, ovarian neoplasm develops in 15. Of this number the lesion is malignant in 9.

In the study of carcinoma of the ovary after hysterectomy, the Mayo Clinic reported that of a total number of 1,500 cases, there were 65 in which the lesion occurred after hysterectomy, an incidence of 4.3 per cent. At the Chicago Lying-In Hospital there were 316 cases of ovarian carcinoma, in 9 of which the growth occurred following hysterectomy, an incidence of 4 per cent. Ovarian malignancy accounts for approximately 15 per cent of cases of gynecological cancer. Its growth is insidious and there is no good method of diagnosis. Once the tumor has enlarged sufficiently to become easly palpable, there is a good chance that it already has become widespread. Statistics of the best centers of therapy show a 5-year survival rate of only 10 per cent to 30 per cent.

Present day therapy for ovarian carcinoma is extremely unsatisfactory. It consists mainly of hysterectomy with oophorectomy and, in some cases, omentectomy. In addition, radiation is used and, more recently, chemotherapeutic agents. None of these methods is very effective and consequently the survival associated with this neoplasm is poor.

Removal of the adnexa with routine hysterectomy, however, is not to be taken lightly. The patient should be informed of what the proposed procedure consists of; she should have complete understanding and emotional preparation for the operation, and its benefit to her emphasized. Full discussion of the anticipated operation is mandatory and the patient should be reassured as to the advantages that result from removal of the ovaries with routine hysterectomy.

Estrogen Therapy for All

In benign cases, no patient, regardless of her age, after undergoing hysterectomy which included bilateral oophorectomy, should be denied estrogenic therapy. It should be started as soon as the patient has recovered sufficiently to be

on a regular diet. The choice of estrogen is not of great importance. Because of its inexpensiveness we prefer diethylstilbestrol in doses of 0.5 mg. per day, usually taken at bedtime. There is rarely an indication for parenteral administration since there are many effective oral medications. Nausea, which may be an unpleasant side effect, is encountered only occasionally. When it does occur, the patient should be assured that it will disappear with continued treatment. Rarely, some other estrogen such as estrone sulfate or ethinyl estradiol may be required instead of diethylstilbestrol.

The patient should be maintained on the dosage mentioned for approximately 6 months, at the end of which time the dosage may be changed to 0.5 mg. three times weekly. This therapy usually will prevent atrophy of the reproductive system and maintain the secondary sex characters. In times of emotional stress it may be necessary to increase the dosage temporarily to prevent the development of vasomotor symptoms.

In younger women who are unfortunate enough to require hysterectomy with bilateral salpingo-oophorectomy, the dosage of estrogen prescribed is usually higher. For these patients 1 mg. of diethylstilbestrol a day can be continued indefinitely. In any event it is our feeling that the estrogens should be continued until old age.

There are several advantages to the early and continued administration of estrogen after the above mentioned type of surgery. Tissues subjected to estrogen stimulation heal more rapidly since the blood supply is increased. Furthermore, there is no endocrine imbalance produced. Estrogens maintain the proper hormonal relation and consequently no emotional readjustment is necessary. If the patient already has experienced the symptoms of estrogen lack they will be relieved. It is important to remember that estrogens should be administered for the other reasons mentioned even if the patient is beyond the climacteric and is no longer suffering from vasomotor symptoms.

Estrogenic Substances and Carcinogens

There has always been some question as to whether estrogenic substances are carcinogenic. A few physicians may hesitate to prescribe estrogens on a long term basis for this reason. The fact that sex hormones have been used more or less indiscriminately for the past 30 years without increasing the over-all incidence of genital carcinoma is good evidence that estrogenic substances are not carcinogenic.

In conclusion, then, it is our feeling that if hysterectomy for benign conditions is indicated and if the patient is near or at the age of menopause, bilateral salpingo-oophorectomy should be part of the surgical procedure. By this means, not only is the operation made easier but the possibility of further difficulties in the form of benign or malignant tumor of the ovary in an organ which is already in its senility is eliminated. The patient undergoing this procedure should have the benefit of continued estrogen therapy into old age to prevent the metabolic and atrophic changes which are characteristic of estrogen lack. The dangers of prolonged estrogen administration are more fiction than fact.

The Paper Jungle of Drug Research

To a member of the clinical research staff of a pharmaceutical manufacturer the impact of the new drug law and F. D. A. regulations has been overwhelming. The immediate and unprinted reaction reflects the enormous increase in paper work and the infinite detail that are now demanded of the individual responsible for the clinical development of a drug for a pharmaceutical manufacturer. You have all been regaled by accounts of the size of the current new drug applications. Our latest weighed 550 pounds, and is by no means a record. Sending in supplementary case data on that particular application involved reproducing, collating and forwarding over 80,000 individual sheets of paper!—Irwin C. Winter, Ph. D., M. D., in Journal of New Drugs.

Total Parathyroidectomy in Renal Hyperparathyroidism*

Frank E. Medford, M. D.

The management of the small per cent of patients with renal disease in whose cases bone complications such as severe bone pain and spontaneous fracture develop is very difficult. In the past, administration of base to correct acidosis and cautious administration of calcium and vitamin D have been the usual forms of therapy.[1] The former, however, often has little or no effect on bone pain or healing of dystrophic bone, and the latter form of therapy is dangerous because of the possibility of inducing metastatic calcification.[2]

Parathyroidectomy in azotemic subjects has been considered contraindicated by some;[1] recent attempts at subtotal parathyroidectomy, however, have met with some success.[2,3,4]

First Cases Reported in 1960

The first subtotal parathyroidectomy for renal hyperparathyroidism was reported by Stanbury[2] et al. in 1960. Their patient tolerated the procedure rather well and showed evidence of bone healing and disappearance of bone pain on large doses of calcium and vitamin D without further deterioration of renal function or development of metastatic calcification. The second case was reported by Findley[3] et al. in 1961. In this case three glands were removed and the fourth could not be found. They too demonstrated healing of bone lesions and disappearance of bone pain on large doses of calcium and vitamin D, without complications.

Anderson[4] et al. reported a third case of subtotal parathyroidectomy for azotemic renal osteodystrophy. They pointed out that the bone disease may be osteomalacia, osteitis fibrosa and osteosclerosis. They suggest that osteitis fibrosa should be demonstrated and a trial of vitamin D instituted before surgery is undertaken. Their results were comparable to those previously reported.

Moore[5] et al. also reported a case of parathyroidectomy for renal osteodystrophy in 1961, and Stables[6] et al. reported a case of parathyroidectomy for hypercalcemic crisis in renal osteodystrophy.

*Presented before a conference at Charleston Memorial Hospital on March 2, 1965.

Submitted to the Publication Committee, February 27, 1965.

The Author

- **Frank E. Medford, M. D., former Senior Resident in Medicine, Charleston Memorial Hospital; now engaged in private practice at Butner, North Carolina.**

A woman with severe bone pain, spontaneous fractures and chronic pyelonephritis preceded by bilateral oophorectomy and gastric resection for ulcer has recently had total parathyroidectomy at our hospital, and the gratifying results seem to warrant report of the case.

Case Report

A 54-year-old white female was admitted to Charleston Memorial Hospital on July 16, 1964 with the complaints of severe bone pain and inability to get up from her bed.

The date of her first admission to this hospital was March 16, 1960 at which time wire sutures were removed from an old cholecystectomy incision. Other abnormalities found on this admission were urine specific gravity of 1.012 and protein content of 200 mg. per cent, and a 1 cm. ulcer crater on the lesser curvature of the stomach. In spite of an ulcer regimen abdominal pain persisted. She was readmitted on October 9, 1961 and because of achlorhydria and failure of the ulcer to heal after several weeks of medical therapy, subtotal gastrectomy was done with a Hofmeister antecolic isoperistaltic anastamosis. The ulcer proved to be benign. Abnormalities during this admission were urine specific gravity of 1.012, phenolsulfonphthalein excretion of 8 per cent in 2 hours, absent left kidney demonstrated by intravenous pyelography and old rib fractures on the left. There was no proteinuria; blood urea nitrogen and serum calcium and phosphorus were normal.

She was discharged from another hospital on July 9, 1963 with the diagnoses of gouty arthritis, osteoporosis, right renal calculus, chronic pyelonephritis, convulsive disorder, late-latent syphilis and anemia secondary to gastrectomy.

Her third admission to Memorial Hospital was on February 26, 1964 when she developed symp-

toms of congestive heart failure which were accompanied by neck vein distention, tender hepatomegaly and pedal edema. There was normocytic, normochromic anemia, urine specific gravity of 1.005, and microscopic hematuria and pyuria. The urine grew coagulase positive Staphylococcus. The blood urea nitrogen was 27 mg. per cent with a serum creatinine of 1.8 mg. per cent and phenolsulfonphthalein excretion of 9 per cent in 2 hours. The alkaline phosphatase was 31.3 King-Armstrong units. Serum calcium, phosphorus, electrolytes, uric acid and proteins were normal. Needle biopsy of the liver yielded normal tissue. Intravenous pyelography showed faint visualization of the right kidney with blunting of the calices. She was discharged improved on digitalis and diuretic therapy.

She was seen on numerous occasions in July 1964 and treated symptomatically for severe bone pain, weakness and anorexia. Deterioration and the consumption of large quantities of anileridine for relief of bone pain prompted the current admission. The family reported that she had a traumatic fracture of the right leg in 1952, an appendectomy in 1943, removal of tubes and ovaries at age 19, hysterectomy, tonsillectomy and left nephrectomy. The dates of the latter three procedures could not be remembered, but the left kidney was removed because of infection.

On admission the patient was semistuporous, lethargic, incoherent, frail, markedly malnourished and dehydrated.

The blood pressure was 118 mm. Hg. systolic and 84 mm. Hg. diastolic; temperature was 98 F. orally, pulse 80 per minute and respirations 26 per minute. Eyelids were edematous; pupils reacted slowly to light, and the fundi showed class 1 arteriosclerotic changes. The carotid pulsations were normal, and no masses were palpable in the neck. Expiratory wheezes were heard throughout the lungs. Heart sounds were distant, and the left cardiac border was at the left midclavicular line. No murmurs were heard. There was questionable ascites, and the liver extended four fingerbreadths below the right costal margin. Bowel sounds were hypoactive. There was 1 plus pitting edema of the ankles. No reflexes could be elicited in the legs, and there was a questionable left peripheral facial weakness.

Hemoglobin was 9.2 Gm. per cent with a hematocrit of 30 vol. per cent. The white blood count was 11,000/mm^3 with 82 per cent segmented neutrophiles, 15 per cent lymphocytes and 3 per cent eosinophiles. The urine was yellow and slightly cloudy with a pH of 5, specific gravity of 1.006, 30 mg. per cent protein and no sugar. The sediment contained 8-10 red blood cells, 10-12 white blood cells and moderate bacteria per high power field. Sedimentation rate was 46 mm. in one hour (Wintrobe). Fasting blood sugar was 114 mg. per cent. Blood urea nitrogen was 122 mg. per cent. Serum electrolytes showed a sodium of 139 mEq. per liter, potassium 5.8 mEq. per liter, chlorides 110 mEq. per liter and carbon dioxide combining power of 11 mEq. per liter. Serum iron was 170 micrograms per cent with an iron-binding capacity of 357 micrograms per cent. Serum calcium was 5.7 mg. per cent and phosphorus 8.8 mg. per cent. The alkaline phosphatase was 22.8 King-Armstrong units. The serum creatinine was 8.2 mg. per cent, total bilirubin 0.15 mg. per cent with 0.08 mg. per cent direct acting, and cholesterol 146 mg. per cent with 73 per cent esters. The creatinine clearance was 8.8 ml. per minute. Cephalin flocculation was 2-plus at 48 hrs. The VDRL was nonreactive. Skull x-rays showed

Table 1

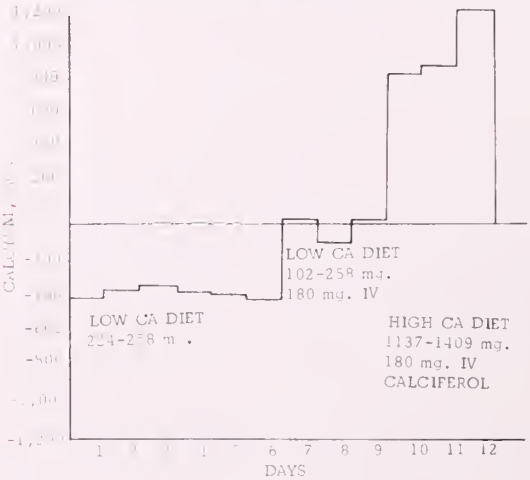
	Serum							Urine				
Date	BUN mg.%	NA mEq/L	K mEq/L	Cl mEq/L	CO_2 mEq/L	CA mg.%	P mg.%	RBC /hpf	WBC /hpf	Prot. mg.%	Alk.P'tase K-A u.	Therapy
7-16-64	122	139	5.8	110	11	5.7	8.8	8-10	10-12	30	22.8	I.V. Fluids & Electrolytes
7-30-64	72	140	5.1	104	18	9.3	6.8	15-20	10-12	75		Polymyxin B I. M. Diethylstilbesterol
8-21-64	43	138	5.3	101	22	8.8	4.0	0	Rare	75		
9-14-64	35					7.1	5.2	Rare	Rare	0	14.6	2 Units Whole Blood
9-15-64	41	140	5.5	105	18							Parathyroidectomy
11-18-64	40	140	4.5	103	25	9.3	4.7	0	Rare	0		15 Gm. CA lactate PO 200,000 Calciferol PO
12-3-64	50					13.4	3.4					0.6 Gm. CA lactate PO 50,000 Calciferol PO
12-10-64	42					10.5	4.4					

calcification of the internal carotid arteries in the region of the sella, and decreased bone density. X-rays of the lumbar spine showed decreased density and rotation of the vertebral bodies. X-rays of the feet and ankles showed moderate decrease in bone density and healing fracture of the second, third and fourth metatarsals bilaterally. A KUB film was normal. A Papanicolaou smear was class II. The electrocardiogram showed slightly low voltage but no other changes. X-rays of the hands showed moderately decreased density.

The patient was treated with intravenous fluids, appropriate electrolytes, antibiotics and multivitamins. Changes in blood chemistry and urine appear in Table 1. The urine grew *Pseudomonas aeruginosa* with a colony count of over 100,000 per ml., which was sensitive only to Polymyxin B. She was given this antibiotic, 25 mg. intramuscularly, every six hours from July 30, 1964 to August 13, 1964, after which urine cultures were repeatedly sterile. Diethylstilbesterol was then started at a dosage of 10 mg. twice daily by mouth.

On September 14, 1964, she was given two units of whole blood. Repeat serum creatinine was 1.7 mg. per cent and creatinine clearance 9.0 ml. per minute. The hemoglobin was 11.9 Gm. per cent with a hematocrit of 35 vol. per cent. With a daily fat intake of 100 Gm., a six-day stool collection contained 8 per cent fat calculated as a percentage of dry weight. On a regular hospital diet the urinary calcium ranged from 30-60 mg. per 24 hours, the urinary phosphorus ranged from 500-700 mg. per 24 hours, and the fecal calcium was consistently greater than the dietary intake. A brief balance study was then done to determine if a positive calcium balance could be attained in view of the previous gastrectomy (Figure 1).

FIGURE I
PREOPERATIVE CALCIUM BALANCE



On September 15, 1964, four enlarged parathyroid glands were removed under general anesthesia; no other glands were found in the neck. The long surgical procedure was well tolerated. The parathyroid glands were about twice normal size and showed chief-cell hyperplasia with very little fat (Figure 2).

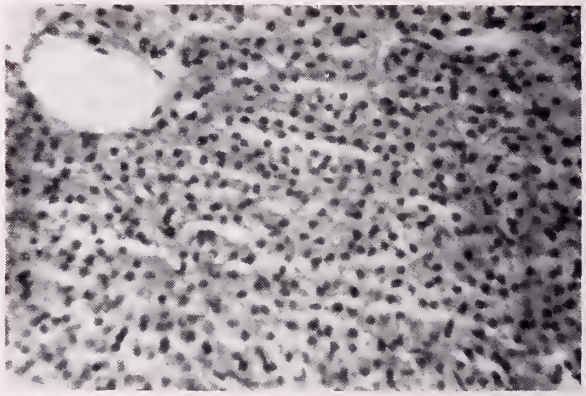


Figure 2

Oral and intravenous calcium intake following surgery were recorded daily and are shown in Figure 3. Serum calcium and phosphorus were determined each morning and afternoon and the daily urinary excretion of calcium and phosphorus were measured following surgery. These values appear in Figures 4 and 5. Intravenous calcium was given in the form of calcium gluconate beginning on the day of parathyroidectomy. By the 16th postoperative day the requirement for intravenous calcium was so great that 10 per cent calcium chloride was added to the calcium gluconate. Oral calcium gluconate was begun the day following surgery, but due to gastrointestinal intolerance this was changed to calcium carbonate after three weeks. Because of insolubility of the latter compound large

FIGURE III
POSTOPERATIVE CALCIUM INTAKE

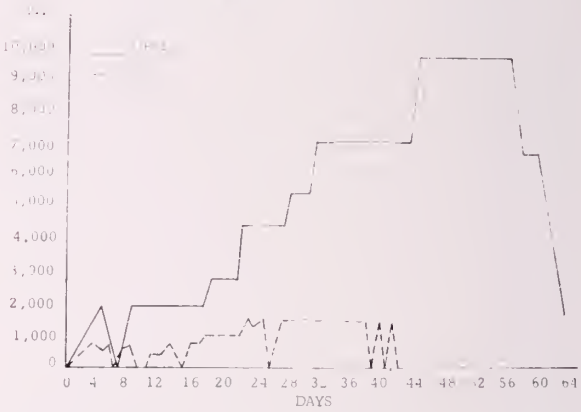
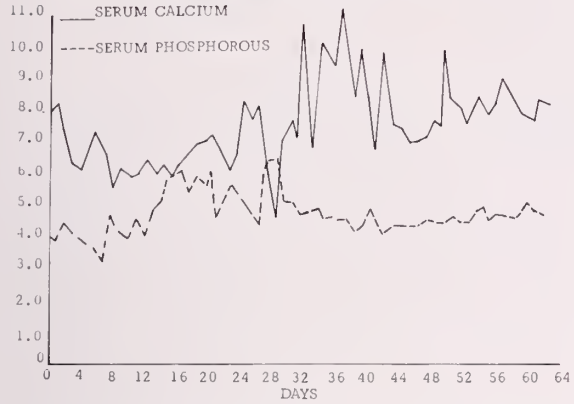


FIGURE IV

POSTOPERATIVE SERUM CALCIUM AND PHOSPHOROUS

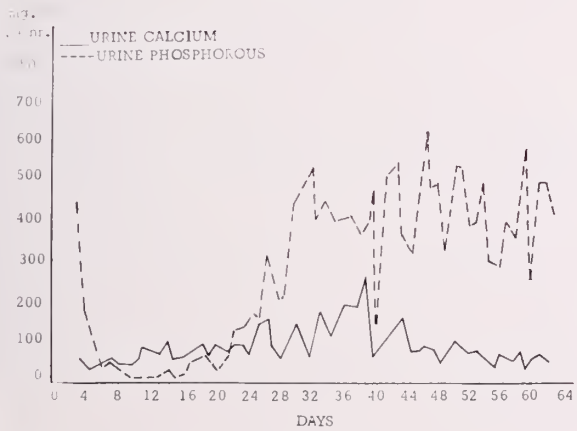


quantities were required; these large quantities, however, were well tolerated. One week before discharge the calcium carbonate was changed to calcium lactate in an attempt to reduce the quantity of oral medication. The calcium lactate was also well tolerated.

The postoperative course was uneventful until the 29th day when an attempt to discontinue intravenous calcium therapy was followed by ileus, lethargy and weakness associated with a positive Chvostek's sign but no frank tetany. The serum calcium at this time was 4.7 mg. per cent. The electrocardiogram, which was normal before surgery, showed symmetrically inverted T-waves in all leads. Intravenous calcium was reinstituted and the symptoms and signs disappeared; the T-wave abnormalities returned to normal as the serum calcium rose to normal. No other electrolyte abnormalities occurred during this period, and there were no changes in the SGOT or LDH enzymes. Spotting from the cervical stump occurred on November 10, 1964;

FIGURE V

POSTOPERATIVE URINE CALCIUM AND PHOSPHOROUS



Progesterone 50 mg. was given daily for six days, and then it and the estrogen were discontinued followed by cessation of spotting.

The patient gained to 120 pounds over the next few weeks and by November 18, 1964 was walking, eating ravenously and able to care for herself. Intravenous calcium was discontinued on the 43rd postoperative day. She no longer complained of bone pain and was discharged on November 18, 1964 on 15 Gm. of calcium lactate and 200,000 units of Calciferol daily by mouth.

The patient was seen in the clinic on December 3, 1964 complaining of severe weakness in the legs for one week, associated with depression and spontaneous crying. Examination revealed no physical changes. The blood urea nitrogen was 50 mg. per cent, the serum calcium 13.4 mg. per cent and phosphorus 3.4 mg. per cent. The calcium lactate was decreased to 600 mg. and the Calciferol to 50,000 units daily. After one week the serum calcium had fallen to 10.5 mg. per cent and the patient felt much better. She was seen again in the clinic on January 7, 1965, and was able to walk and felt better generally. Her blood urea nitrogen was 41 mg. per cent, serum calcium 7.3 mg. per cent and phosphorus 5.5 mg. per cent. She was instructed to increase the calcium lactate to 1.8 Gm. and the Calciferol to 100,000 units daily. Repeat x-rays February 2, 1965 revealed no changes in the bone density, and she was started on diethylstilbesterol 5 mg. twice a day.

Discussion

The well known problem of differentiating primary hyperparathyroidism with secondary renal disease from secondary hyperparathyroidism due to renal disease was not paramount in our case, since renal disease was diagnosed before onset of changes in serum calcium and phosphorus. Without this information, the history of ulceration of the stomach perhaps would tend to make one favor the diagnosis of primary hyperparathyroidism. Our case differs somewhat from those in previous reports in that females in those reports were all under age forty and presumably had functioning ovaries, whereas in our case the patient had been without ovaries for years. It is unlikely that the administration of estrogens alleviated the bone pain because of the short period of administration.

In Figure 1 it can be seen that a positive calcium balance was obtained with large doses of oral calcium and vitamin D. It might be contended that this would be a contraindication to parathyroidectomy and, indeed, Anderson[4] et al. imply as much. It must be remembered, how-

ever, that with large doses of calcium and vitamin D one may produce metastatic calcification in these subjects with intact parathyroid glands. In fact, Stanbury[2] et al. and Findley[3] et al. suggest that the reason for parathyroidectomy in these subjects is to allow the administration of large doses of calcium and vitamin D without taking the risk of inducing metastatic calcification.

Figure 3 shows that in our case intravenous calcium salts were necessary for about forty days. This period of time is somewhat longer than the 16 days reported by Stanbury[2] et al., but perhaps this was to be expected since we removed all identified parathyroid tissue. The oral calcium requirement of our patient during the postoperative period is impossible to determine because of lack of a complete balance study and the necessity of changing calcium preparations due to intolerance. After three weeks the oral calcium gluconate was changed to calcium carbonate, and one week before discharge calcium lactate was substituted for the carbonate.

It is significant that the fecal excretion of calcium exceeded the dietary intake. This is characteristic of the vitamin D resistance of the uremic state. The correction of the acidosis did not reverse this situation and only after large doses of Calciferol did a positive calcium balance occur. It is possible that the previous gastric resection interfered with calcium absorption enough to produce osteomalacia with bone pain and even secondary hyperparathyroidism; with this condition, however, one would expect steatorrhea. The fecal fat excretion in our patient was not abnormal. Osteomalacia may occur in gluten sensitive enteropathy without steatorrhea,[7] but such an occurrence after gastric resection is not so clearly defined. In addition, the increased calcium absorption produced by large doses of vitamin D is more typical of the uremic state than the altered mechanics of gastroenterostomy.

The calcium and phosphorus changes shown in Figures 4 and 5 are to be expected after parathyroidectomy and are similar to those which occurred in Stanbury's patient. In that case, there was a more profound drop in serum phosphorus postoperatively than in ours, but both had marked decrease in urinary phosphorus excretion in the face of decreased serum phosphorus. The decrease in urinary phosphorus excretion would be expected after parathyroidectomy with normal renal function, but Stanbury, pointing out that kidneys with glomerular filtration rates of less than 10 ml. per minute do not respond to parathormone, considered that extrarenal factors, acting through change in the serum phosphate level, were responsible for the decreased urinary phosphorus excretion. Two other possible explanations for decreased urinary phosphorus excretion and low serum phosphorus are deposition of phosphorus in bone and poor absorption from the gut. Stanbury showed decreased intestinal absorption of phosphorus and decreased deposition of phosphorus in bone early after parathyroidectomy. This then would suggest that the paradoxical decrease in urinary phosphorus in the face of a normal or decreased serum phosphorus is due to decreased intestinal phosphorus absorption.

The reason for the disappearance of bone pain in these cases is not definitely known but is apparently due to healing of dystrophic bone. Our patient's bone pain disappeared, but her bones showed little x-ray evidence of increased bone density six weeks after surgery. It has been pointed out, however, that renal hyperparathyroidism may be present without bone lesions.[8] Also, the lack of healing as shown by x-rays does not mean that improvement has not taken place, for it is generally known that rather large differences must take place in bones before x-ray differences can be appreciated. A three-day balance study in our case during the latter part of hospitalization revealed that there was retention of about 500 mg. of calcium per day. This may have been related to the effect of estrogen therapy on bone matrix. Our patient has been restarted on estrogens in the hope of accelerating bone healing.

It seems that the only real reason for parathyroidectomy in renal osteodystrophy is alleviation of bone pain, which is accomplished by the administration of large doses of calcium and vitamin D. There is no convincing evidence that the renal disease is improved and, although healing of osteitis fibrosa has been demonstrated and could conceivably improve bone strength, there is no evidence that this alone indicates need for the operation.

Summary

A case of severe pain associated with renal hyperparathyroidism in a patient with chronic pyelonephritis, previous gastrectomy, oophorectomy and left nephrectomy is presented. After adequate treatment of the metabolic acidosis and pyelonephritis, four enlarged parathyroid glands were removed. These showed chief-cell hyperplasia. She required intravenous calcium for about forty days after parathyroidectomy and shortly before discharge the bone pain began to subside. She was given large doses of Cal-

ciferol and calcium salts by mouth, and it is reiterated that parathyroidectomy allows this form of therapy without the danger of inducing metastatic calcification.

References

1. Albright, F. & Reifenstein, E. C., Jr.: Parathyroid Disease and Metabolic Bone Disease; Selected Studies, 393 pp. Baltimore, Williams and Wilkins, 1948.
2. Stanbury, S. W., Lumb, G. A. & Nicholson, W. G.: Elective Subtotal Parathyroidectomy for Renal Hyperparathyroidism, Lancet 1:793, 1960.
3. Findley, T., Moore, J. D. & Brackney, E. L.: Subtotal Parathyroidectomy for Renal Hyperparathyroidism, Lancet 2:1150, 1961.
4. Anderson, W. W., Mann, J. B., Kenyon, N., Farrell, J. J. & Hills, A. G.: Subtotal Parathyroidectomy in Azotemic Renal Osteodystrophy, New England J. Med. 268:575, 1963.
5. Moore, J. D., Brackney, E. L. & Findley, T.: Parathyroidectomy for Renal Osteodystrophy, Trans. Am. Clin. Climat. Assoc. 73:186, 1961.
6. Stables, D. P., Levin, N. W., Rubenstein, A. H., Beck, M. E. & Abrahams, C.: Parathyroidectomy for Hypercalcemic Crisis in Renal Osteodystrophy, Ann. Int. Med. 61:531, 1964.
7. Moss, A. J., Waterhouse, C. & Terry, R.: Gluten-Senstitive Enteropathy With Osteomalacia but Without Steatorrhea, New England J. Med. 272:825, 1965.
8. Klein, L., Albertson, K. & Curtis, P. H., Jr.: Urinary Hyperparathyroidism: Study of Three Cases With and Without Bone Lesions, Metab. 11:1023, 1962.

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Special Article

Some Psychological Problems of Criminality

Max Plutzky, M. D.

We are living in a changing world; new ideas, discoveries and methods are frequently taking place and new problems are being confronted. Not very long ago individuals suffering an emotional problem were considered and called "degenerates." With a better understanding of human motivation and mind dynamics, this concept has changed and, as a consequence, psychiatric and legal approaches have changed too. Until very recently the prevalent attitude toward criminal behavior was punitive but fortunately this has been changing and we can see how therapy and rehabilitation are more and more indicated in the approach to this kind of problem. This situation has created the need of psychiatrists appearing more frequently in court and of law men becoming familiar with psychiatric terms and having a clearer concept concerning the motivation and origin of criminal behavior in order to understand the problem better and administer justice.

When approaching an antisocial act, it would be superficial to do so from the point of view of right or wrong and to bear in mind only what the punishment should be. That punishment alone is not the simple answer to criminality is supported by the fact that it has not been an effective deterrent, even in those states in which capital punishment is a statute. I quote Beccaria in "An Essay on Crime and Punishment": "The punishment of a crime cannot be just if the laws have not endeavored to prevent that crime by the best means which time and circumstances would allow."

What Makes a Criminal?

Why does an individual become a criminal and how can we prevent this happening? The answer obviously is not simple and multiple complex factors are involved. When we review the most frequent of the psychological factors involved in criminal behavior, we can say that no human being is a born criminal. A child follows in his behavior what we know in psychoanalysis as the "pleasure principle." He seeks mainly satisfaction of his instinctive needs without taking reality factors into consideration. But through the process of socialization and education he learns to adapt the satisfaction of his needs to his environmental cultural demands of behavior adapting then, when he becomes an adult, an acceptable pattern of social conduct. Some persons are not capable of achieving this and they still keep acting out their immature needs, following the above named pleasure principle, and seeking mainly gratification with disregard of their environmental codes, thus producing criminal behavior. This group of individuals constitutes what we call in psychiatry "antisocial personalities" or psycopaths. They have had problems in their past which did not allow them to develop an adequate conscience; they have very little guilt feelings, care only about their needs, go through the world feeling that it is there for the sake of their wishes and have an ego extremely weak, being very poor in tolerating frustration. Frequently we see that these individuals come from an emotionally and economically deprived environment, usually with a poor parenthood situation—the mother promiscuous, the father an alcoholic, or there may be no father at all but, instead, different men coming in and out of the home. The child grows, deprived of the necessary love and security, with a great degree of frustration and with no suitable model or no ideal to copy.

We know that what makes a child educable and willing to give up his antisocial traits or ways of satisfaction is the rewarding love of his parents—the love so necessary for him to survive. If he does not have this, he does not feel the need of giving up his primitive ways of satisfaction. Why would he do so if there is no re-

The Author

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Submitted to the Publication Committee, March 22, 1965.

ward? We see, too, that due to his life conditions, his self-image is one of a subhuman group, which produces great social frustration and increases strong inferiority feelings which, in turn, produce hostility as a defense. Society, then—and at times this is a true factor—is blamed for the individual's frustration and becomes the target of his anger. He expects to be looked down upon as a projection of how he looks at himself. He feels society owes him something and that he has a right to take it. We can see, then, that there is not just one factor involved but a combination of factors.

The Child Identifies

Another cause of delinquent behavior is the consequence of the presence in the child's environment of a wrong figure to copy. The normal trend of every child is to grow up by copying the models with whom he lives; this we call identification, a primordial process. If the figure with whom he identifies is antisocial, one might expect the person who is copying also to behave in a wrong way.

In other cases we see individuals who have been raised by a strict, domineering, authoritarian parent against whom there is a great deal of unconscious hostility that the individual may act out by displacing it against substitute figures such as bosses, policemen, teachers and institutions. These individuals are really attacking symbolic parental figures.

The Scapegoat Mechanism

A certain twisted relationship between parent and child recently has been studied in which the interaction between them produced a delinquent individual. In this case the person's criminal behavior is a response to the parent's unconscious antisocial needs. The individual commits antisocial acts with the parental figure obtaining vicarious gratification from the child's behavior. As an example we can cite the case of a boy who used to steal and whose mother would become depressed when he would not, but whose depression disappeared when he again stole. She had been married to an antisocial man and the boy's delinquent behavior began after the father's death. In this case the boy was a scapegoat utilized unconsciously by the mother—first to act out her antisocial wishes and then to alleviate the guilt of her forbidden impulses. He was the one who stole, not she; this pointed him out as the criminal, reassuring herself of her own innocence making him, by this, a scapegoat. Speaking of scapegoats, we sometime witness other types of antisocial activities more subdued and disguised, executed by a group of people with several rationalizations to avoid guilt when a scapegoat in the form of a minority, like a religious or racial group, is used as the target of instinctive aggressive needs. These scapegoat mechanisms have been used by analysts to explain why prevention of criminality has been so unsuccessful, stating that criminals and law offenders may be needed as scapegoats of aggressive groups.

In other cases, criminal behavior is the result of guilt feelings. When the individual feels guilty because of deep emotional problems, he commits some antisocial act that brings punishment with the unconscious purpose of eliminating guilt-anxiety to get relief.

We also talk sometimes about impulsive characters with an ego intolerant to tension and incapable of delaying action by thinking, but with the need of discharging their impulses immediately. Their actions are less directed toward the positive aim of achieving a goal but more toward the negative one of getting rid of tension. If their drive is of an aggressive nature this could produce antisocial activities.

Mental Retardation and Other Illnesses

Mental retardation in its gross form and with a low I.Q. could be a factor in criminal activity, but mental retardation in a mild form becomes a determinant factor when the person, feeling that he cannot compete successfully with the group, develops inferiority feelings. He may react to this by proving to the group that he dares to do what others do not on account of fear of the consequences. This makes him notorious which is a way of getting attention and achieving importance; he therefore becomes a tough and fearless individual, accepted and praised by the members of the gang.

We also have to mention briefly drug addicts who really are sick personalities unable to tolerate psychic pain or frustration. These are frequently unhappy people because of guilt feelings or anxiety and who try to avoid their unhappiness by creating a false elation state and stupifying their consciousness with the action of several chemical substances.

Another important group are those who have been labeled sexual abnormal behavior individuals, those whose ways of sexual satisfaction or sexual partners differ very much from our normal pattern and who can find relief of their sexual tension only through their symptoms. This situation makes therapy more difficult if we consider that the illness is in itself a pleasant goal. They also usually come to us under the threat

of legal punishment which is not the ideal therapeutic situation.

Until now we have been reviewing emotional illnesses expressed in terms of patterns of behavior and with a good contact with reality—what we call "personality disorders," but there remain other groups that deserve our attention.

The Other Groups

1. Schizophrenic patients showing an important break with reality who under the influence of hallucinatory or delusional experiences would commit criminal acts, like the person who kills because he heard the voice of God compelling him to do so.

2. Paranoid patients who become antisocial, when based on their paranoid ideas, will try to destroy their imagined persecutor or accordingly with their paranoid jealousy may try to eliminate their "love rival."

3. Depressed psychotic patients who live in constant torment may feel that the world is a suffering hell. And when acting out their suicidal impulses may kill their children also, not with the idea of murdering them but with the pious goal of sparing them from the world's sufferings.

4. Another type of antisocial activity that has been reported as increasing lately and that is performed mainly by schizophrenic or psychopathic parents is the physical abuse of children (the battered child syndrome).

Good Mental Health and a Better Society

As stated before, the solution of criminality is not simple. Until now, it seems that the role of the psychiatrist has been mainly that of a skilled technician determining responsibility in regard to criminal acts. But we think there is a much more important role—the one regarding disposition and rehabilitation. This will necessarily involve many professional and nonprofessional groups, even the whole community, as part of a mental health program with the goal of creating a better society.

The psychiatrist as a clinician could participate actively in treatment carried on in his office, in hospitals, or in prisons, individually or in group sessions. As consultant to mental health community programs he could advise regarding education of the general public, children's behavior, school education, family interaction, and the importance of the environment in creating adequate and acceptable social ideas.

What of Our Prison System?

Another important aspect that requires our attention is the improvement of our prison system with more emphasis on rehabilitation by helping the individuals to acquire training and skills to use in life. A better and more adequate grouping of the individuals in prison is essential too. The preparation of society to readmission of the individual through information and education is also an important step. How can somebody re-enter society if, after his first offense, he is labeled an ex-convict and cannot find anyone to associate with except other criminals who help him to raise and increase bitter feelings against society?

Assassination of President Kennedy

A tragic event, the assassination of President Kennedy, and the subsequent event of Oswald's death by a self-appointed executioner, called much more attention to aggressive behavior and made all of us think about the problem some people present with a preventive approach. What can we do with these individuals who have a fragile or weak ego with poor control over their aggressive impulses? They are not psychotic; they are not incompetent; they don't show a break with reality, but we know that in certain circumstances, they might be involved in an antisocial act. How do we approach that situation? Treatment might be the ideal answer if the individual wants to accept it, but if he doesn't what will be the answer then? This is an important area much neglected from the preventive point of view that requires the conjoint attention, work and research of psychiatrists, jurists, and law-enforcing agencies along with sociologists interested in crime and delinquency. The task perhaps seems difficult but, at the same time, it appears as a promising, rewarding challenge.

References

1. Nice, R. W.: Criminal Psychology.
2. Fenichel: Psychoanalytic Theory of the Neurosis.
3. Noyes & Kolb: Modern Clinical Psychiatry.
4. Nice, R. W.: Crime and Insanity.
5. Walt, J. R.: Presidential Address, Am. J. Psychiat., Vol. 121, No. 1, (July) 1964.
6. Eissler, K. R.: Searchlights of Delinquency.

'The Known Quantity'

Advocates of generic prescribing are probably motivated by good intentions: They want people to pay as little as possible for their drugs, and they want the drugs to be of uniformly high quality. They argue that if the same drug is made by different companies which respectively conform to standards of the *U. S. Pharmacopoeia,* then each of the companies' products will be identical and have identical effect upon all patients. Thus, the advocates for generic prescribing continue, the cheapest is just as good as the most expensive. A sound and logical argument? Unfortunately, no, because this simply isn't the case.

The *U. S. Pharmacopoeia* publishes legal standards to which drugs should conform, and it specifies how much *active ingredient* a drug product should contain. But the formulation of a *medicinal dosage* form is something else again. In fact, U.S.P. states that the actual formulating processes through which active drug ingredients become usable medicaments "are, in general, beyond the scope of the *Pharmacopoeia.*" So two or more would-be identical drug forms may conform wholly to U.S.P. standards, but because of differences in formulation, each may produce quite different results in patients.

Is all this to say that generic name drugs are always inferior to trademark products? Of course not, for some of the most reputable drug makers in the nation market generic products. It is a fact, however, that most substandard drugs are sold only under generic names. A trademarked drug from a known manufacturer is a known quantity, but the generic drug is usually anonymous. The simple fact is that a physician can't always rely on generic quality or probable effect.

More than 90 per cent of all prescriptions written are for brand name drugs. And they aren't all that much more expensive in the long pull, for a study of 10,000 welfare prescriptions by the Rhode Island Department of Public Assistance showed that if generic products had been used wherever possible, the savings would have been only 5 per cent of cost. The case for the known quantity—a drug proudly signed by its maker—is a strong one. —Everett Crawford, M. D., in Journal of the Mississippi State Medical Association.

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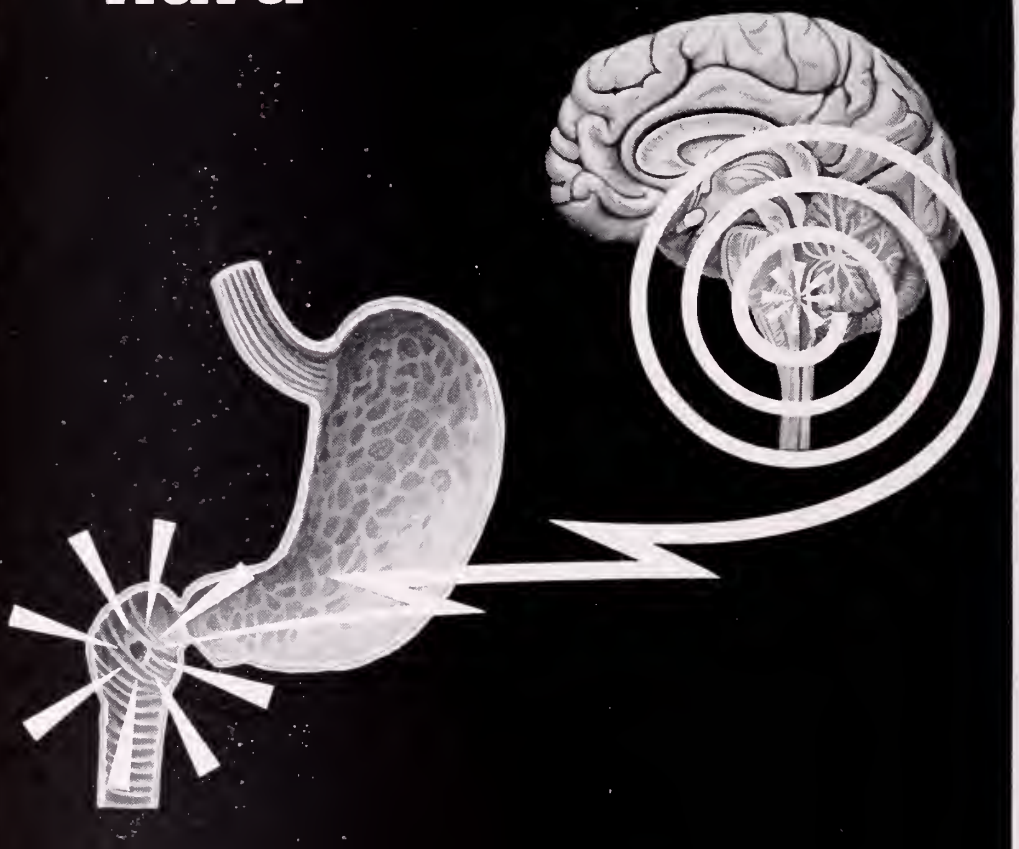

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Research in the Service of Medicine

The President's Page

'IN THE BEGINNING THERE WAS LIGHT'

As your spokesman for the coming year, I shall utilize every opportunity to become more enlightened to the complex problems that each doctor of our great State Medical Association faces in his practice.

I bring you the personal greetings from the officers, the staff and the working committees of your West Virginia State Medical Association, and I sincerely pledge you my maximum efforts. Becoming President of our Association of doctors is one of the highest honors to which any physician can humbly hope to ascend and I am equally conscious of the responsibilities of the office. I devoutly pray that I will have the wisdom and judgment to interpret your needs and carry out a program that will be in the best interests of our membership and our fellowmen, who are in the final court of judgment, the reason for our professional existence and service.

PLAN CO-CO

As the year progresses I will introduce for your consideration several programs which I hope will improve our capability of comprehending your problems at the Local County Medical Society level and to bring about closer cooperation between the officers and committees of the State Association with your counterparts. It is my philosophy that the State Medical Association exists to serve the County Medical Societies, and not the opposite theory which is so often implied. But as we cooperate together the needs of both organizations can best be accomplished.

The second part of our Plan Co-Co, is communication. Again it is a part of my philosophy that there is no problem, regardless of how complex, that cannot be improved if men of goodwill will sit down and discuss it in good conscience. Communication implies many things. It is an interchange of thoughts and opinions. It is a two-way street. To be effective it should be clear, concise and complete, and understood by both parties.

In reference to my responsibility in communication, of which this President's Letter is an important part, I have arbitrarily determined that the greater portion will be devoted to the attitudes and problems of the individual physicians and their County Medical Societies.

In order that our communications can be complete and effective, you have a mutual responsibility of your own to discuss with, and inform the officers of your County Medical Society of your attitude and thinking on the problems that concern the private physician, then they will be able to communicate to us at the state level their advice and recommendations that we can study and consider in carrying out a program that will work to the best interests of organized medicine and the public at large.

Join me in our Plan Co-Co.

Seigle W. Parks, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

PRESERVATION OF THE OVARIES AT HYSTERECTOMY

Elsewhere in this issue may be found an article concerning the question of preservation of the ovaries during hysterectomy. The author properly emphasizes that ovarian tissue should be conserved in young women during the reproductive age. It is suggested, however, that women in need of hysterectomy and who are at or past the climacterium, should also have the ovaries removed. There are several practical surgical advantages which accrue in the removal of the ovaries at the time of hysterectomy. The paramount factor, however, is that excision of these organs precludes the possibility of malignancy developing later.

It is known that sex hormone production for all practical purposes ends with the menopause. The estrogen level of the blood falls to a very low level indeed. There is considerable evidence which indicates that estrogens lower cholesterol levels in the blood and that estrogen lack in females may contribute to hypertension. It is generally conceded, also, that following the menopause women are more apt to suffer a coronary episode. Furthermore, certain somatic changes may occur such as, flabby breasts, changes in the tissue of the vagina and still others.

Because estrogen lack may produce these undesirable changes in the body, many physicians have come to believe that women who have passed the menopause should be encouraged to take estrogenic substances for an indefinite period of time. Physicians who share this philosophy probably would not hesitate to recommend removal of the ovaries assuming that hysterectomy was indicated. If estrogen therapy is recommended anyway following the menopause, it is a relatively simple matter to increase the dose slightly in the event that ovariectomy has been performed.

In all fairness, it should be mentioned that castration in either sex, even in older people, may in some individuals produce psychic trauma. It is likely, however, that this feeling may be more pronounced in the male. Some physicians would probably hestitate to recommend removal of the ovaries, especially those who are loath to prescribe estrogen therapy. In this event they would probably be opposed to bilateral oophorectomy unless these organs were actually diseased. The opinions of these physicians should, of course, be respected, even though they are in the minority. In any event it does appear that modern substitutional therapy is a safe and adequate procedure for those women who have had their ovaries removed.

There is a current belief that as people grow older they sleep less, and they do so because they need less. Perhaps this concept, in part at least, is based on the fact that infants sleep many hours each day (from about 14-20 hours), and that growing children also sleep a great deal (from about 12-14 hours), but that grown people sleep much less. But without further data one should not conclude that older people necessarily need less sleep.

SLEEP IN OLDER PEOPLE

The requirements for sleep of older people have been studied recently by Tiller.[1] He modestly points out that his study is largely subjective; for example, he acknowledges that it is difficult for a person to be sure of the exact time spent sleeping, and also it is hard to evaluate the symptoms complained of by older people. The data he presents, however, are provocative.

He reported sleep patterns in 83 mentally alert and physically active office patients age 60 or over during a period of eight months. Of this group 53 were less than 70 years old and 30 were 70 or older. The symptoms of which the older people complained were: tension, fatigue, apprehension, dizziness, feeling of confusion, gastrointestinal symptoms, musculoskeletal pain, and headache. It is not in the province of this essay to give in detail the many interesting findings reported by Tiller; suffice it to say that his data indicate the symptoms listed above occur more frequently and are more intense in patients who sleep seven hours or less than in those who sleep eight hours or more.

Tiller concludes that his study does not support the idea that either the amount or the need of sleep decreases with advancing age. He does not, however, attempt to evaluate the clinical significance of his studies.

It is true, of course, that the pattern of sleep varies a great deal in individuals. Some people appear to get along quite well with from five to six hours of sleep, whereas others require from eight to ten hours. This is recognized by Kleitman[2] who has made a life-long study of sleep. He emphasizes the fact that the amount of sleep required is highly individual, but states that the "natural" minimum is from seven to nine hours.

Even though the study made by Tiller is subjective as he admits, his data strongly indicates that older people apparently live more comfortably if they take an adequate amount of bed rest. Certainly the concept that the amount of sleep or the need of sleep decreases with age can be seriously challenged.

1. Tiller, P. M., Jr.: Bed Rest, Sleep, and Symptoms. Annals Int. Med., 61:98 (July) 1964.
2. Kleitman, N.: Sleep and Wakefulness, revised ed., University of Chicago Press, Chicago, 1963, p. 121.

Last Sunday our minister used this interesting analogy: Will we be thermometers or thermostats? Will we just register the changes that occur around us, or will we act as regulators of our environment?

THERMOMETER OR THERMOSTAT

Let us apply this philosophy to our present day problems with the complex changes that are taking place in our practice of medicine. First, we must identify and define what these changes are now and what they may become later. Next, we must clearly delineate whether these changes are primarily those of the social environment around us, or whether they are changes within the body of organized medicine. In order to understand the effect of these new laws, we must not only understand the wording of these regulations, but also their application and implications.

All of the aspects alluded to above are complex and confusing and will require much study and discussion before it makes much sense to any of us. But at this point let us, for the moment, decide whether we will be thermometers or thermostats. Will we assume a passive role and register the changes that take place in the practice of medicine and more specifically in our own practice, or will we become sufficiently sophisticated not only to record these changes but to interpret the future results, then institute processes that will act to alter our future medical environment in a manner more suitable to ourselves, but also to the long established principle of what is in the best interests of our patients.

Let us think about the technical specifications of a thermostat. It can record temperature changes but is primarily an automatic device for regulating temperature, for actuating fire alarms or for controlling automatic sprinklers, etc. The key word of course, is that it is automatic, it must be set by a human mind to do certain things when certain critical conditions arise. It is this human element that is all important.

Have certain critical changes taken place in the socialization of medicine that we are now ready to sound the fire alarms and drown out this smoldering fire that threatens to burn down that structure which has taken so long to build,

or is the human mind capable of reprogramming its thermostat to register the minute changes as they occur, to analyze their potential effect, and then set in motion corrective actions to beneficially alter their final results?

Let us now consider this all important element—the human mind—the regulator or programmer of those various thermostats. What is the character of this mental process? What are its motivations? What are its goals?

As it is most difficult to define the intricate development of the human personality, it is infinitely more complex to understand the group personality with its manifest variants. Basically, the constructive and destructive drives are constantly in turmoil struggling for a balance or proper fusion in the individual or within a group. This is bound to produce anxiety and discord until an acceptable balance can be accomplished. This can best be understood within our own personality, when our environment is so altered to constitute a threat to our security and to all those cultural and moral values we have been taught through medical school and years of practice that are necessary to the preservation of the highest standards of medical practice and service to our patients.

The basic reaction to threat is to fight or flight —or to hold in abeyance our instinctual reaction until we have had the opportunity to search our intellectual processes and the possible repercussions of our contemplated action—before we take a more considerate course of action.

What am I trying to say? Now is the time for considerate introspection. Now is the time for self-examination. What is the mind of the body medicine politic? Do we have the intellectual capacities, individually or in concert action to study the implications of the Social Security Law, to accept that portion which may be beneficial, and to define those portions that are threatening to the optimum benefit of our patients, and work for its legislative improvement or abolishment?

This is our challenge to act as thermostats. To define our personal and group reactions to this environmental and professional threat. To make deliberate and specific studies to improve our understanding of this socio-medical upheaval, and then in our capacities as thermostats act to alter these environmental influences.

First we must analyze ourselves, next our local groups, and following synthesis of these opinions at the state level, develop a course of action to this threat. Will it be fight or flight?—*Seigle W. Parks, M. D.*

Rapid Reading

We are being urged from many quarters to learn to read more rapidly, say up to twelve hundred words a minute. Some of us may attain that speed but all of us could read faster. Many educators and executives agree the man who reads more learns more and achieves more. Some persons find reading to be tedious. If they could read faster it would be more interesting. Perhaps a little guidance would make it more effective.

Before reading what may be an interesting article give it a quick survey searching for important phrases. This will help decide how much is worth careful reading and sometimes it will suffice.

Read in phrases. It increases speed and improves concentration and comprehension. A person can think much faster than he can read. Slow reading permits the mind to wander. Phrase reading keeps the eyes and mind busy.

Concentrate when reading. Inattention and distraction impede efficient and rapid reading.

Skip and skim. This grows directly out of pre reading. Skipping means passing over some material, while skimming is the rapid recognition of significant phrases and salient facts. We do not say scan for this means careful perusal of every word.

Increase the vocabulary. Rapid and efficient reading depends on quick recognition of a wide range of words. The most effective way to build a wide vocabulary is to read something every day. Some words send us to the dictionary but when next encountered they are more familiar.

We have read some articles that could not mean any less at twelve hundred words a minute than when read more leisurely because their meaning was confused and buried in a vast wordage. Perhaps the slow and careful study of literary nonsense would not yield any more than a rapid, cursory reading. Reading a twelve hundred word article in one minute may not yield as much meaning as it would if the same article were written in five hundred words that might also be read in one minute. On the other hand, what about thoughtful writing with substance and literary finesse where every word has grace and carries meaning?

We are very much in favor of rapid reading within reason but we are also in favor of tight writing within reason. There is no place in medical writing for prolixity or verbosity, ramification or confusion.

Rapid reading calls for clear writing—Charles Sellers, M. D., in Detroit Medical News.

'Nonexistent' Drug Reactions

It is all very well for the profession and the public to be alert and alarmed at drug reactions, and to do everything in their power to keep these at a minimum. Nevertheless, to me the pendulum has swung much too far in the other direction, to the extent that many individual members of the public, to my personal knowledge, are more concerned about non-existent reactions than they are with the evident benefit they have obtained from the drug they are taking.—Irwin C. Winter, Ph.D., M.D., in Journal of New Drugs.

GENERAL NEWS

18th Annual Rural Health Conference At Jackson's Mill on Sept. 30

Dr. W. Wyan Washburn, Chairman of the Council on Rural Health of the American Medical Association, will be the keynote speaker at the 18th Annual Rural Health Conference which will be held at Jackson's Mill on Thursday, September 30. The theme for the one-day Conference is "Health Is A Way of Life."

W. Wyan Washburn, M. D.

Doctor Washburn, who is a practicing physician in Boiling Springs, North Carolina, has served for several years as Chairman of the AMA Council and has been a participant in several previous conferences at Jackson's Mill.

More than 250 persons are expected to attend the Conference which is sponsored annually by the West Virginia State Medical Association in cooperation with the Agricultural Extension Division of West Virginia University, the West Virginia Home Demonstration Council, the State Department of Health, the West Virginia Farm Bureau and the West Virginia Congress of Agriculture.

Dr. Martha J. Coyner of Harrisville, who is in charge of the program for this year's Conference, will call the meeting to order in the Assembly Hall promptly at 10:00 A. M. (EST). The invocation will be given by the Rev. Joseph P. DeBardi, Minister of the First Methodist Church in Clarksburg.

Following the keynote adress by Doctor Washburn, a program on "Cardio-Pulmonary Resuscitation" will be presented by staff members of the Heart Disease Control Bureau of the State Health Department.

There will be a showing of a color film entitled "Pulse of Life" and a demonstration of external cardiac massage and mouth-to-mouth breathing. The following staff members of the Heart Disease Control Bureau will participate in the program:

Dr. N. Allen Dyer, Director; Dr. Edwin C. Neville, thoracic surgeon of Charleston and consultant to the Bureau; and Mr. Calvin C. Paul, Public Health Advisor.

Luncheon will be served in the Mt. Vernon Dining Hall at 12:15 P. M. with the West Virginia State Medical Association as host.

Afternoon Session

Dr. Seigle W. Parks of Charleston, President of the State Medical Association, will deliver the address of welcome at the opening of the afternoon session. Following his address, the remainder of the afternoon session will be devoted to a panel discussion on "As The Twig Is Bent . . ."

Doctor Coyner will serve as moderator and she announced that the speakers will discuss emotional problems of children, teenagers and college students. The following members of the West Virginia University faculty have accepted invitations to participate in the panel discussion:

Dr. Robert L. Vosburg, Professor and Chairman of the Department of Psychiatry, WVU School of Medicine; Dr. W. Gene Klingberg, Professor and Chairman of the Department of Pediatrics, WVU School of Medicine; and Joseph C. Gluck, Director of Student Affairs at the University.

Doctor Coyner emphasized that ample time will be allotted for a question and answer period with full audience participation.

The Conference is open to members of all interested groups and a formal invitation to attend the meeting is being extended to members of local farm bureaus, home demonstration councils, agricultural extension workers and personnel of local health departments.

Convention Story Will Appear In October Journal

The 98th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

Advisory Committee

The program for the Conference was planned by members of the Advisory Committee to the State Medical Association's Rural Health Committee.

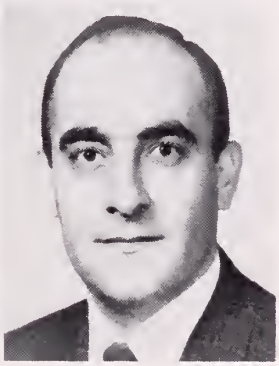
In addition to Doctor Coyner, the other members are Miss Gertrude Humphreys of Morgantown, former State Extension Home Demonstration Leader; Dr. N. H. Dyer, State Director of Health; Mrs. Elizabeth Roberts Bare, former Foods and Nutrition Specialist of the Extension Service; Mrs. E. D. Curry of Fairmont, President of the West Virginia Home Demonstration Council; Mrs. George A. Curry of Morgantown, immediate past president of the Woman's Auxiliary to the State Medical Association; and Mr. E. O. Gregory of Buckhannon, Secretary of the West Virginia Farm Bureau.

Cabell Society Completes Symposium Plans

Additional details have been announced for the Cabell County Medical Society's 11th Annual Symposium on Rheumatoid Arthritis, which will be held at the Hotel Frederick in Huntington on September 9.

The guest speakers include: Dr. Barry Decker, Director of Medical Education at Richmond Memorial Hospital in Richmond, Virginia; Dr. J. D. O'Duffy of the Department of Rheumatic Disease at the Cleveland Clinic; Dr. William H. Kammerer, Clinical Associate

John W. Soshea, M. D.



Barry Decker, M. D.

Professor of Medicine at Cornell University Medical College; Dr. John W. Soshea, a Rheumatologist at St. Petersburg, Florida; and Dr. Rolla D. Campbell, Jr., Clinical Assistant Professor of Orthopedic Surgery at Cornell University Medical College.

Registration will be conducted starting at 8 a. m. Doctor Decker will present his paper beginning at 9 a. m. Doctor O'Duffy will discuss "Recent Advances In Gout" beginning at 10:30. A question and answer session will follow his presentation.

Doctor Kammerer will be the first speaker at the afternoon session. Doctor Soshea will speak on "Some Aspects of Rheumatoid Arthritis in Patients Over 65," and Doctor Campbell's topic will be "Surgical Treatment of Arthritis."

There will be no registration fee for the symposium. Dr. T. F. Scott is chairman of the committee in charge of arrangements.

13th Annual Medical Seminar In Bluefield on Oct. 14

The 13th Annual Medical Seminar, sponsored by the Bluefield Sanitarium, Stevens Clinic and Clinch Valley Clinic, will be held at the Bluefield Country Club in Bluefield on Thursday, October 14.

The scientific session at the one-day meeting will begin at 2:00 P. M. and there will be a reception and banquet that evening. The banquet speaker will be Mr. Thomas J. Anderson, Editor-in-Chief of Southern Farms Publications.

Speakers for the scientific session and their subjects will be as follows:

"Cancer of the Breast."—Jerome Urban, M. D., Memorial Hospital, New York City.

"Mammography."—Gerald D. Dodd, M. D., Professor of Radiology, Jefferson Medical College Hospital, Philadelphia.

"Renal Artery Surgery."—Eugene F. Poutasse, M. D., Devine-Poutasse Urological Group, Norfolk, Virginia.

"Renal Hypertension."—Dante Castrodale, M. D., Department of Internal Medicine, Stevens Clinic Hospital, Welch.

"Closed Chest Cardiac Massage."—James P. Thomas, M. D., Thoracic Surgeon, Bluefield Sanitarium Clinic, Bluefield.

Dr. Robert W. Neilson, Jr., of Bluefield, is Chairman of the Seminar Committee.

Second Edition of WVU Diet Manual Available to Physicians

The second edition of the West Virginia University Medical Center Diet Manual has been published and a complimentary copy was mailed last month to each hospital in the State through the courtesy of the state dietetic and hospital associations.

Dr. Margaret A. Wilson, Director of the WVU Hospital Dietetic Department, announced that an adequate supply of the manuals had been printed and that copies are available for interested physicians.

The price of the manual is $2.00 and orders should be directed to the WVU Dietetic Department, WVU Medical Center, Morgantown.

United Fund Status Given To Arthritis Unit

The Charleston Branch of the Arthritis Foundation has been admitted to membership in the United Fund of the Kanawha Valley.

Dr. Daniel Hamaty, President of the Charleston unit, noted that membership relieves the branch of conducting its own fund-raising campaign and "gives us more time for development of our service program."

The Charleston Branch was established a year ago for diagnosis, evaluation and treatment of arthritis patients.

State TB and Thoracic Groups To Meet In Huntington

The annual meeting of the West Virginia Tuberculosis and Health Association will be held at the Frederick Hotel in Huntington on September 16.

Gov. Hulett C. Smith will be the speaker at a banquet, and Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, will be the luncheon speaker.

General session speakers will include Miss Helen Ostwald, Deputy Director of Field Program Services, National Tuberculosis Association in New York; Dr. M. L. White of Huntington; and Dr. Thomas W. Nale, Director of the Cabell-Huntington Health Department.

The West Virginia Thoracic Society, the medical advisory section of the West Virginia Tuberculosis and Health Association, will hold its annual business meeting at 11 a. m. Dr. Preston C. Davis of Beckley, president of the Society, will preside.

Symposium on Hodgkin's Disease

The American Cancer Society and the National Cancer Institute will sponsor a Symposium on Hodgkin's Disease at the New York Hilton Hotel in New York City on November 22.

The latest clinical and research information on Hodgkin's Disease will be presented. There is no advance registration or registration fee.

Further information may be obtained by writing to Dr. Jack W. Milder, Research Department, American Cancer Society, 219 East 42nd Street, New York, N. Y. 10017.

Diabetes Program Completed

Plans have been completed for the annual meeting of the West Virginia Diabetes Association, which will be held at Blackwater Falls State Park on September 12.

Papers will be presented by Drs. John C. Floyd of the University of Michigan Medical Center; L. Lewis Pennock of the University of Pittsburgh and Paul C. Davidson of West Virginia University Medical Center.

Dr. Floyd's topic will be "Early Diagnosis and Prophylactic Treatment of Diabetes." Doctor Pennock will speak on "Juvenile Diabetes and Mass Diabetes Detection," and Doctor Davidson's paper is entitled "The Relationship of Insulin Responsiveness to Plasma Triglyceride Level."

Doctor Naum Gets College Post

Dr. George P. Naum, Jr., of Wheeling has been appointed part-time physician at West Liberty State College.

A 1963 graduate of the West Virginia University School of Medicine, Doctor Naum has practiced for two years at the Woodsdale Clinic.

Tape Recordings Are Released To Medical Profession

A library of more than 300 one-hour tape recordings, covering everyday medical office problems, has been released to the medical profession by the Audio-Digest Foundation of Los Angeles, a nonprofit subsidiary of the California Medical Association.

The 1965 "Catalog of Classics" makes available to physicians, hospitals and others teaching material in the areas of anesthesiology, obstetrics-gynecology, surgery, pediatrics, internal medicine, ophthalmology and general practice. There are other tapes on basic sciences, cancer, psychiatry, gastroenterologys, cardiology, arthritis, geriatrics and hematology.

Many of the recordings are edited reports from the meetings of such groups as the American Medical Association, the American College of Physicians and others.

The catalog is available free of charge by writing to the Foundation Editorial Offices at 619 South Westlake Avenue, Los Angeles 90057.

Mental Health Meeting in Charleston

The West Virginia Association for Mental Health will conduct its 11th annual meeting at the Daniel Boone Hotel in Charleston, September 24-25.

Sid Ross of Parade Magazine will speak on "Services for Emotionally Disturbed Children." Other features of the meeting will include an art exhibit by Huntington State Hospital patients, a progress report by Dr. Mildred Mitchell-Bateman, State Director of Mental Health; and a reception at the home of Dr. and Mrs. John W. Hash.

Heart Association Plans September Meeting

The 1965 meeting of the West Virginia Heart Association will be held at Blackwater Falls State Park near Davis, September 10-11.

Features of the meeting will include a session of the board of directors, scientific sessions for physicians, non-medical sessions for laymen, membership luncheon and awards banquet.

The speaker for the banquet will be Dr. Wallace R. Heatwole, president of the Virginia Heart Association.

The president of the West Virginia Heart Association is Dr. A. C. Thompson of Elkins. He will be succeeded by the president elect, Dr. A. D. Kistin of Beckley.

The theme for the scientific sessions will be "Hypertension." Four members of the staff of Cleveland Clinic will present papers. The speakers and their subjects are:

Dr. David Humphrey, "The Use of Antihypertensive Drugs;" Dr. William Kiser, "Diagnosis and Treatment of Renovascular Hypertension;" Dr. F. Merlin Bumpus, "Renal Factors in Hypertension;" and Dr. Harriet P. Dustan, "Some Factors Responsible for Hypertension."

Industrial Medical Association Plans Pittsburgh Meeting

The Industrial Medical Association of the Pittsburgh-Cleveland Area will hold its Fall Scientific and Annual Business Meeting on Friday, September 24, at the Mellon Institute in Pittsburgh.

The program will include a panel discussion on "Physical Stresses in the Work Environment—Health Assessments and Health Maintenance." Another feature will be a presentation by an attorney on "Medical-Legal Aspects of Cardiac Disease."

Additional information may be obtained by writing to Dr. Edwin A. McGovern, c/o Jones and Laughlin Steel Corp., 2812 East Carson Street, Pittsburgh, Pennsylvania 15203.

PG Course in Pulmonary Disease

A postgraduate course in pulmonary disease will be conducted in Columbus, Ohio, September 24-25.

The course is sponsored by the College of Medicine of Ohio State University, the Ohio Tuberculosis and Health Association and the American and Ohio Thoracic societies. The registration fee is $30.

Additional information may be obtained by writing to Ohio State University, The Center for Continuing Medical Education, 320 West Tenth Avenue, Columbus, Ohio 43210.

Tom K. Mura Joins Blue Shield

Tom K. Mura has resigned as Assistant Director of the American Medical Association's Communications Division to take a post with the National Association of Blue Shield Plans.

Mr. Mura was appointed Director of the Blue Shield Association's Communications Division. During his seven years with the AMA, he also worked in the Legal and Socio-Economic Division and was Associate Editor of *The AMA News*.

Foundation Lists PG Courses

The Cleveland Clinic Educational Foundation has scheduled five postgraduate courses between now and the end of the year. Courses and the dates are:

September 10, "Medical Technology"; September 29-30, "Recent Advances in Clinical Pathology"; October 6-7, "Gastroenterology: Diseases of the Colon and Rectum"; October 13-14, "Selected Topics in Hematology"; and November 3-4, "Recent Advances in Medical Treatment."

Further information may be obtained by writing to the Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

AMA To Hold National Congress On Medical Ethics

The American Medical Association will sponsor a National Congress on Medical Ethics and Professionalism at the Drake Hotel in Chicago, October 2-3.

The conference will provide physicians an opportunity to exchange ideas on ways to emphasize the concern of all physicians with the high standards of conduct traditionally associated with medicine.

A highlight of the meeting will be a speech by Dr. James Z. Appel, President of the American Medical Association. His topic wil be "Medicine, a Profession or a Business?"

Another speaker will be Dr. Walter H. Judd, a former Congressman and curently a member of the AMA Judicial Council. He will discuss the accomplishments and deficiencies in the medical profession's standards for ethical deportment.

Speakers will discuss such subjects as "Professionalism, a Trust in Perpetuity," "When Ethics and Welfare Programs Clash" and "Can Ethics be out of Tune with the Times."

Workshop topics will include: appeals to state ethics boards and to the AMA Judicial Council, medicine and the law, medicine and pharmacy, and interpretation of unethical conduct by local standards.

Advance registration forms and additional information may be obtained by writing to Dr. James H. Berge, Chairman of the Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Doctor Jenkins Resigns

Dr. Robert A. Jenkins has resigned as superintendent of the Colin Anderson Center for mentally retarded children at St. Marys.

Doctor Jenkins announced he plans to open offices for the private practice of psychiatry in Parkersburg this fall.

Medical College of Georgia Plans Seminar

A two-day seminar on "The Immediate Care of the Sick and Injured" will be conducted at the Medical College of Georgia in Augusta, September 9-10.

A geust faculty will join with the staff of the Medical College in discussing the proper handling of the injured and the acutely ill by those who are first called to the scene such as ambulance drivers, police officers, rescue squad members, firemen and other.

The registration fee will be $10. Registration and all communications should be sent to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

Syphilis Is Increasing At Alarming Rate

An alarming over-all picture of venereal diseases in West Virginia was cited by State Health Director N. H. Dyer in a recent issue of the "State of the State's Health." Since 1957, the state has seen a 338 per cent increase in infectious syphilis. The increase during fiscal year 1965 over the preceding year was 51 per cent as compared to a nationwide increase of only 4 per cent.

Doctor Dyer noted that two-thirds of all infectious venereal diseases reported in West Virginia occurred in persons under 25 years of age. The state still ranks near the top each year in the rate of admittances to mental institutions with psychosis due to syphilis.

A $59,176 project grant to support a much-needed syphilis eradication program was recently awarded to the State Department of Health by the U. S. Public Health Service.

Doctor Dyer pointed out, however, that if West Virginia is to accomplish eradication of infectious syphilis by 1972—its stated goal—education, communication, and information concerning venereal diseases must be disseminated to the public with the help of local health departments, physicians, schools, parents and civic and church leaders.

In another issue, Doctor Dyer discussed the fatalistic public attitude toward cancer. According to Doctor Dyer, "If people were aware of the large number of cancer patients who are living full and normal lives, the melancholy side of cancer would be greatly de-emphasized."

He pointed out that early diagnosis, along with prompt and adequate treatment, is vital in the control of cancer. He indicated that although only half of the newly reported cancer cases last year were diagnosed while the disease was still localized, a more optimistic picture is emerging with the aid of the West Virginia Central Cancer Registry which can provide more detailed figures on all aspects of cancer.

As an example of early diagnosis and treatment, Doctor Dyer discussed a demonstration project in Cabell and Kanawha counties, supported through a federal grant to the West Virginia Association of Pathologists, which resulted in the screening of 6,000 indigent and medically indigent women. Of these, 100 early cancers were discovered which would most likely not have been diagnosed until too late. Dr. Peter Ladewig, chairman of the project, explained that through the use of cytology procedures, the superficial cancer cells may be detected when they have just formed a beach-head but not yet become entrenched in the tissues and can therefore be eradicated without difficulty.

Another aid mentioned by Doctor Dyer which has increased early diagnosis is the mobile chest x-ray unit operated as part of the tuberculosis control program. Last year, the unit uncovered 373 tumors, of which a large number proved to be cancer of the lung. These tumor reports represented 7.3 per cent of the 5,113 abnormal findings.

He stated, "That control of cancer is a significant public health problem is underscored by the fact that last year cancer caused the death of 2,674 West Virginians and during the same period approximately 5,000 new cases were diagnosed. Research provides hope for the future, but education, early diagnosis and adequate treatment furnish hope of the present."

U. S. Doctors Volunteer Services To Vietnam Civilians

The number of American doctors in Vietnamese provinces will soon be increased through a joint effort of the Agency for International Development and a new voluntary organization known as "Project Vietnam."

Under the program, American doctors will volunteer for two months' service in Vietnam. The program will provide 20 doctors at a time and will more than double the number AID has assigned to Vietnam at the present time. It was created in response to the President's request for more U. S. medical assistance for Vietnam. Project Vietnam is being administered by The People-to-People Health Foundation, Inc., Washington, D. C.

Project Vietnam will provide transportation and a monthly substance allowance for each doctor. An AID contract signed in July with the voluntary organization will call for an expenditure of $500,000 a year over a three-year period.

AID now has medical teams in four provincial cities. Each team is made up of two or three physicians, a like number of nurses, one laboratory technician and one hospital administrator.

The new program will raise the number of AID doctors in Vietnam to 35. The first doctor was to leave for Vietnam by the middle of August. He is Dr. Richard E. Perry, an orthopedic surgeon of St. Petersburg, Florida. He will be followed later by three more orthopedic surgeons, eight general surgeons, and eight general practitioners.

The new organization will review applications from volunteers. Requests for information should be directed to Project Vietnam, 2233 Wisconsin Avenue, N.W., Washington, D. C. 20007.

Medical Aspects of Sports Meeting in Philadelphia

The Seventh National Conference on the Medical Aspects of Sports will be held in Philadelphia on November 28 in connection with the annual Clinical Convention of the American Medical Association.

The conference is sponsored by the AMA Committee on the Medical Aspects of Sports.

Subjects to be covered include sports trauma to the head and neck, readiness for sports participation, weight control in wrestling and the knee in sports.

Major Medical Benefits Approach $1 Billion

Major medical expense insurance protected 47,001,000 Americans by the end of 1964, and benefits from this coverage amounted to $942,528,000 for the year, the Health Insurance Institute reported recently.

Major medical was introduced 15 years ago by insurance companies to provide a high level of benefits for serious illness or injury. Both in coverage and benefits, major medical registered record highs last year. Some 4,560,000 more persons (10.7 per cent) were protected under this insurance in 1964 than in 1963, and total benefits were $129,778,000 higher.

The Institute noted that of the 151,123,000 persons with some form of health insurance in 1964, 31 per cent had major medical protection by insurance companies. Major medical year-end coverage figures over the last decade and a half depict the increasing acceptance of major medical expense insurance and the role it plays in the personal economies of millions of American families, the Institute declared.

In 1951, 108,000 persons in the United States had major medical; by 1955, the total had risen to 5,241,000; and five years later, 1960, he total increased five-fold to 27,448,000. Insurance companies provide major medical under group programs (usually at places of employment) and through individual and family type contracts.

These policies provide benefits for almost every type of necessary medical expense prescribed by a physician for an illness or injury both in or out of hospital including x-ray, prescribed medicines and drugs, medical appliances, physician's services, charges by registered nurse, and ambulance or other needed transportation, among other services.

Most major medical policies have two cost-sharing features—the deductible and coinsurance. The deductible is the amount the insured pays before benefits begin. Depending on the policy or contract, the deductible can range from $50 to $1,000 or more.

After the deductible, the benefits under the policy pay 75 or 80 per cent of the remaining bills. Benefits can range from $5,000 to $25,000.

Drug Cure for Smoking Habit?

The breaking of the smoking habit may be amenable to a pharmacological agent. In this area too we can treat a condition satisfactorily only when a meaningful theory offers an explanation of the fundamental aspects. I have postulated . . . that the inhalation of burning tobacco leaves creates an irritation of the mucous membranes of the respiratory tract. This physical irritation vies competitively with the vicisstitudes of every day living for acceptance by the central nervous system. A suitable counterirritant applied to the throat could then effectively substitute for smoking.—Adolphe D. Jones, M. D., in Experimental Medicine and Surgery.

The Hard Case for Safety Glasses

We surround ourselves with safety glass in our automobiles, our offices, and our homes but neglect this safeguard in something much closer to us—our eyeglasses.

Technology now provides eyeglass lenses that are tough, shatter-resistant, and optically perfect. They can be made of case-hardened glass, laminated glass, or optical-grade plastic.

To qualify as a safety lens the hardened lens must withstand the impact of a steel ball one-half inch in diameter dropped from 50 inches above onto its front surface. An ordinary glass lens would break into needle-sharp fragments under such a test.

Sunglasses as well as prescription lenses can be made of safety material, which is only a few grams heavier than ordinary material. In the case of sun glasses alone the extra cost is $2.00 for plastic and $5.00 for case-hardened glass. Surely this is a small premium to pay for such insurance.

Those who particularly need this protection are children; those with sight in one eye only and who require corrective glass for that eye; those who work in laboratories with corrosive and explosive materials; those who operate power lawn mowers, particularly of the rotary type; those who operate power tools; and those who garden, particularly in brush and shrubs, or use insecticide sprays.

Safety lenses have been mandatory for industrial use for many years. The law is quite specific about it. The law of survival is expected to operate outside of industry. It is too often honored in the breach.

The eye is well protected by the over-hanging brow and the up-thrusting malar eminence; but when the globus is covered with fragile glass, it is exposed to a new danger that may strike at any time—fregmentation, penetration, infection, scarring, and the whole dreary train that may lead to loss of vision.

Poets have said that the eye is the window of the soul. It is also our principal contact with the world in which we live—a priceless sense, and no contingency should be overlooked toward its conservation.—New York State Journal of Medicine.

PG Course in Biology

The American College of Physicians is sponsoring a postgraduate course in "Molecular Biology: Its Implications for Modern Medicine."

The course will be conducted October 27-28 at the University of Chicago Center for Continuing Education in Chicago. Fees are $60 for ACP members and $100 for nonmembers.

Registration forms and additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

West Virginia ACS Chapter Arranges Program

Two guest speakers are on the program for the fall meeting of the West Virginia Chapter of the American College of Surgeons, which will be held in Morgantown on October 1-2.

They are Drs. Mark M. Ravitch, Associate Professor of Surgery at Johns Hopkins University School of Medicine in Baltimore, and Albert Paquin, Chairman of the Department of Urology at the University of Virginia School of Medicine in Charlottesville.

Doctor Ravitch will discuss the newer aspects of treatment of omphalocele in the newborn and the application of mechanical stapling devices to general and thoracic surgery.

In his papers, Doctor Paquin will discuss the surgical management of disorders of the ureterovesical junction and also the epidemiologic and experimental aspects of urinary tract infections.

Papers also will be presented by members of the faculty of the Department of Surgery at the West Virginia University School of Medicine.

New Association Members

Dr. Fernando Dominguez, 1145 Fourth Avenue, Huntington (Cabell). Doctor Dominguez, who was born in Mexico, was graduated from the University of Mexico and received his M. D. degree in 1951 from the University of Mexico School of Medicine. He interned at Juarez General Hospital in Mexico City, and served a residency at Cabell-Huntington Hospital. His specialty is surgery.

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Dr. George P. Naum, Jr., 885 National Road, Wheeling (Ohio). Doctor Naum, a native of Charleston, was graduated from Marshall University and received his M. D. degree in 1963 from the West Virginia University School of Medicine. He interned and served a residency at Wheeling Hospital, 1963-65. He is engaged in general practice.

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Dr. James E. Powers, 1330 Mercer Street, Princeton (Mercer). Doctor Powers, a native of McDonald, Ohio, attended the two-year WVU School of Medicine and received his M. D. degree in 1959 from the Medical College of Virginia. He interned at Roanoke Memorial Hospital, 1959-60, and served a residency at the Medical College of Virginia Hospitals, 1960-64. He was previously located in Orlando, Florida, and his specialty is surgery.

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Dr. David E. Wallace, 12 Leftwich Avenue, Madison (Boone). Doctor Wallace, a native of Van, was graduated from Morris Harvey College and received his M. D. degree in 1963 from the West Virginia University School of Medicine. He interned at Charleston Memorial Hospital, 1963-64, and he is engaged in general practice.

Medical Meetings

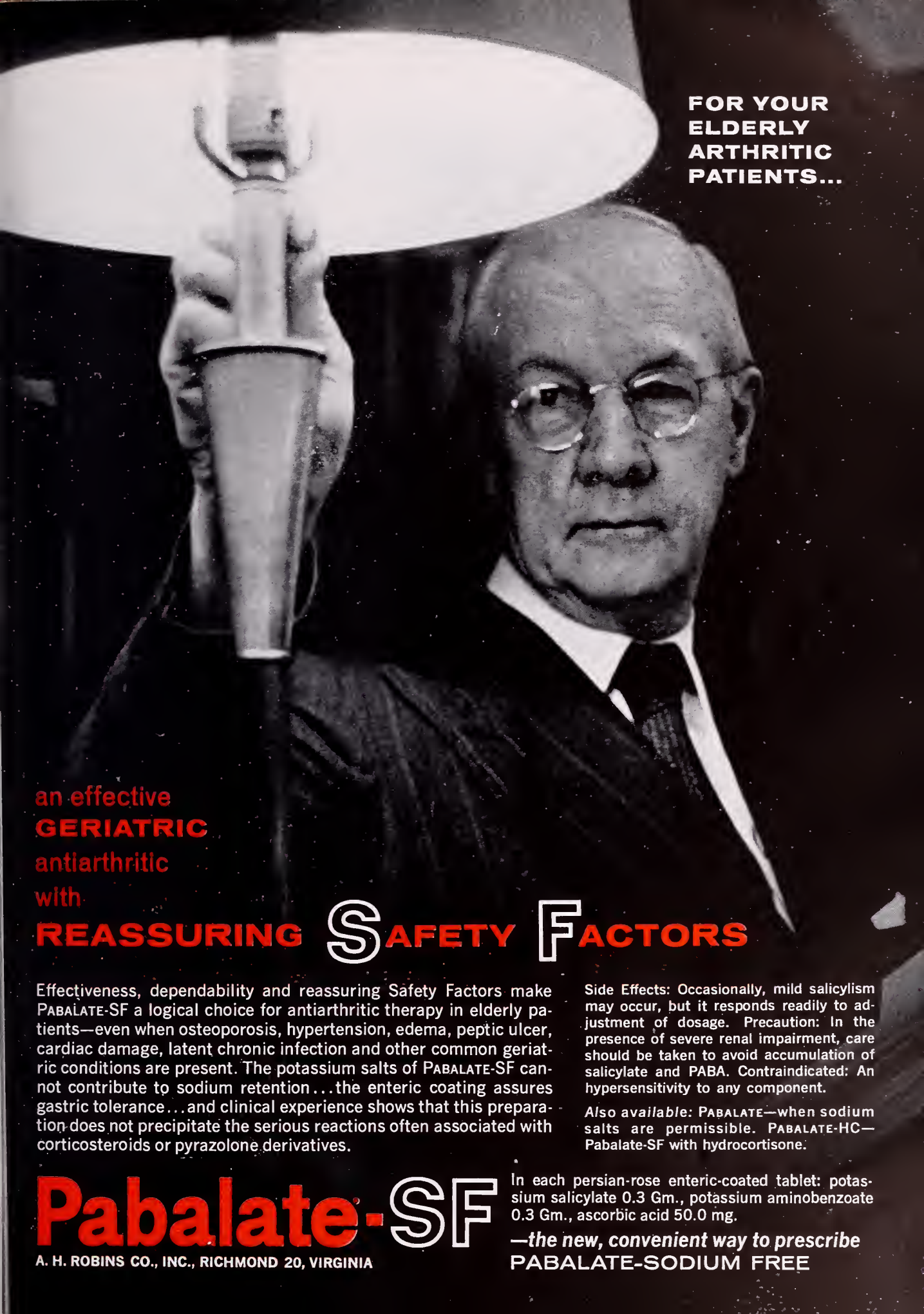
The following is a partial list of national, state and district medical meetings scheduled for the next year.

1965

Sept. 9—Cabell County Symposium, Huntington.
Sept. 9-11—American Assn. Ob.-Gyn., Hot Springs, Va.
Sept. 10—Maryland Medical Society, Ocean City.
Sept. 11—W. Va. Heart Assn., Blackwater Falls State Park.
Sept. 16—W. Va. TB & Health Assn., Huntington.
Sept. 18-26—Pennsylvania Medical Soc., Atlantic City, N. J.
Sept. 19-25—World Medical Assembly, London.
Sept. 21-23—Kentucky Medical Assn., Louisville.
Sept. 23-25—W. Va. Hospital Assn., White Sulphur Springs.
Sept. 30—Rural Health Conf., Jackson's Mill.
Oct. 1-2—W. Va. Chapter, ACS, Morgantown.
Oct. 7-9—ACP, Miami Beach.
Oct. 8-10—W. Va. Div., Am. Cancer Soc., Wheeling.
Oct. 10-13—Medical Soc. of Virginia, Richmond.
Oct. 13-15—W. Va. Nurses Assn., Pt. Pleasant.
Oct. 15-19—American Heart Assn., Bal Harbour, Fla.
Oct. 15-22—Col. of American Pathologists, Chicago.
Oct. 18-22—ACS Clinical Cong., Atlantic City.
Oct. 23-27—Am. Soc. of Anesthesiologists, Denver.
Oct. 23-28—Am. Acad. of Ped., Chicago.
Oct. 24-27—Am. Col. of Gastroenterology, Bal Harbour, Fla.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical Assn., Houston.
Nov. 14-19—American Acad. of Oph. & Otol., Chicago.
Nov. 27-28—ACCP, Philadelphia.
Nov. 27-Dec. 3—Radiological Soc. of N. America, Chicago.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Feb. 1-5—Am. Col. of Radiology, Chicago.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
April 25-28—Industrial Med. Assn., Detroit.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.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WVU Medical Center
—News—

SCHOLARSHIPS were awarded recently to 35 students enrolled in the School of Medicine. The $1,000 Pfizer Laboratories Scholarship was awarded to Fred A. Brindle, a sophomore medical student from Martinsburg. The Harris Scholarship of $350, named in honor of Dr. Thomas L. Harris of Parkersburg, was awarded to Richard H. Sibley of Nitro.

Three Collins Foundation Scholarships were awarded to James C. Cosmides, Wheeling junior ($500); Hugo J. McClung, Hartford junior ($450); and Maritsa P. Cosmides, Wheeling senior ($700).

Scholarships of $400 each from the Claude Worthington Benedum Foundation were awarded to:

Jerome Arnett, Rowlesburg junior; Arlo P. Brooks, Jr., Sissonville senior; Patricia M. Gregg, Morgantown senior; Albert J. Kolibash, Benwood junior; Leonard G. Prutsok, Philippi sophomore; and William Renforth, Follansbee senior.

Board of Governors Graduate Scholarships, covering tuition, were awarded to 24 students. They are:

First-year students—Charles R. Bauer, New York, N. Y.; Robert J. Fagioletti, Grindstone, Pa.; Linda S. Frangowlakis, Williamson; William D. Hawley, Jr., Princeton; Richard J. O'Brien, Jr., Wheeling; and Mary A. Shemo, Charleston.

Second year—James W. Campbell, Weirton; W. Albert Dow, Clairton, Pa.; Frederick C. Newton, Hinton; Marion B. Tallent, Jr., Martinsburg; William E. Walker, Ripley; Ronald L. Wilkinson, Charleston.

Third-year—James C. Cosmides, Wheeling; James F. Grow, Jr., Cuyahoga Falls, Ohio; Larry H. Harper, Clendenin; Joseph R. Metz, Erie, Pa.; David A. Santrock, Dunbar; and Nancy A. Spitznogle.

Fourth-year—James M. Brantly, St. Albans; Paul M. Chikos, Jr., Logan; Patsy B. Cipolloni, Jr., Masontown; Phillip M. Park, Petersburg; Samuel A. Strickland, Summersville; and Arthur A. Trowbridge, Jr., Morgantown.

Two MD's On Hospital Program

Two members of the faculty of the School of Medicine will be among speakers on the Inaugural Scientific Program at the new Ancker Hospital in St. Paul, Minnesota, November 11-13.

They are Drs. Edmond B. Flink, Professor of Medicine, and Russell V. Lucas, Jr., Associate Professor of Pediatrics. Both formerly were on the staff of the hospital.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

45,000th Patient

West Virginia University Hospital admitted its 45,000th patient on July 1, almost five years after it opened.

Director Eugene Staples said about 90 per cent of the patients have been West Virginians. The hospital now has 380 beds and an additional 70 will be put into service in October.

University Hospital recently received a three-year renewal of its accreditation by the Joint Commission on Accreditation of Hospitals.

Staff Members Present Papers

Dr. Edward J. Van Liere, Professor of Physiology and Dean Emeritus of the School of Medicine, presented a paper on August 25 at the fall meeting of the American Physiological Society in Los Angeles.

The title of the paper was "Regression of Cardiac Hypertrophy Following Exposure to Hypoxia," and it was co-authored by Dr. Barbara Krames, Assistant Professor of Biology, and Jeffrey M. Yost, a third year medical student from Paden City.

Dr. Michael Wilson, the new Chairman of the Department of Physiology, will present a paper entitled "Adaptation of the Cardiovascular Response to Exercise" on September 4 at the 23rd International Congress of Physiological Sciences in Tokyo.

Also on September 4, Doctor Wilson will participate in a symposium on "Cardiovascular Integration."

While in Japan, Doctor Wilson will visit Hiroshima at the invitation of a friend, Dr. Hiroshi Irisawa, Chairman of the Department of Physiology at Hiroshima University.

Research Programs Completed

Thirty-four students will complete ten-week programs as research fellows at the West Virginia Medical Center on September 12.

The students were hired for the summer months to aid in research work in the School of Medicine. Most are being supported by a general grant from the National Institutes of Health.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.

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The Month in Washington

• From the Washington Office of the American Medical Association.

HEALTH, Education and Welfare officials are drafting rules and regulations for operation of the new Social Security medicare law. The new law provides for persons 65 years and older a basic hospitalization plan financed with Social Security taxes and a subsidized, voluntary, supplementary medical insurance program. Both programs will start July 1, 1966.

The existing Kerr-Mills program of medical assistance to the needy and near-needy aged is expanded and combined with all the other federal-state medical assistance programs into one plan with simplified administration, a uniform grant formula, specified benefits and minimum eligibility requirements.

Self-employed physicians are brought under Social Security retroactive to January 1, 1965. They will be required to pay next April $259.20 each in Social Security taxes for this year. The tax will go up to $405.90 for 1966 and rise over the years to $514.80 by 1987. Physicians were the last profession to be covered by Social Security and the only group to be forced into the system over the protests of its professional organization.

Coverage and liability for taxes for interns and residents will not begin until January 1, 1966.

The new law also increases Social Security cash benefits by an average of seven per cent, retroactive to January 1, 1965.

To finance the new health care programs and the increase in cash benefits, both he Social Security tax base and tax rates will be increased. The tax base will be increased from the present $4,800 of workers' annual pay to $6,600 on January 1, 1966.

Arthur E. Hess, who has been with the Social Security Administration since 1939 and in charge of disability insurance since 1954, has been named to head up the new SSA Bureau of Disability and Health Insurance to handle the medicare program. A spokesman said the SSA, which now has 35,000 employes, will add between 7,000 and 8,000 more in the next year to administer the program.

President Johnson signed the legislation (H.R. 6675) on July 30 in the presence of former President Harry S. Truman, who 20 years ago proposed in his legislative program a national medical insurance plan for all ages financed by higher Social Security taxes.

Commenting on the medicare program becoming law, F. J. L. Blasingame, M. D., executive vice president of the AMA, said in Chicago:

"We will watch developments in this new program and offer constructive suggestions, both to Congress and to the administrators of the program, in the interest of the maintenance of the highest quality of medical care.

"President Johnson has requested that we meet with officials of the Department of Health, Education and Welfare on the development of rules and regulations.

"Following our conference with Mr. Johnson on Thursday (July 28), initial meetings were held with HEW Secretary Anthony Celebrezze, exploring arrangements for AMA and HEW review of projected regulations and of problems of administration and interpretation of the law.

"The President also asked that we report back to him in two months on our progress."

AMA Resolution

The White House conference between Johnson and 11 top AMA elected and staff officials, developed from an action of the AMA House of Delegates in New York last June. The House approved a resolution including the following two resolves:

"Resolved, That this House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States . . .

"Resolved, That the American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association . . ."

The first AMA-HEW conference on medicare at the staff level was held in Washington a week after the program became law. HEW was consulting representatives of the American Hospital Association even before the legislation was signed into law.

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DOSAGE: Children—six years or over—One teaspoonful three times daily for 3 days.

CAUTION: Drowsiness may occur. Use only with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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Obituaries

MARTIN LOXLEY BONAR, M. D.

Dr. Martin L. Bonar, 75, of Charleston died on August 5 at his home in that city.

Doctor Bonar received his M. D. degree in 1919 from Western Reserve University and specialized in dermatology. He was a native of Moundsville.

He was an honorary member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Mila Oppelt Bonar; a brother, Dr. W. P. Bonar of Moundsville; a sister, Mrs. Bertha Kidd of Moundsville; and a granddaughter, Miss Linda Ann Riffe of Parkersburg.

* * * *

HELEN M. BELKNAP FRASER, M. D.

Dr. Helen B. Fraser, a native of Gassaway and a former member of the West Virginia State Medical Association, died on July 16 at a hospital in Louisville, Kentucky. She was 48.

Doctor Fraser, a pediatrician, earned A. B. and B. S. degrees at West Virginia University and received her M. D. degree in 1941 from Rush Medical College.

She was director of the Division of Maternal and Child Health for the West Virginia Department of Health until 1956, when she accepted a similar position in Kentucky. She was a member of the Kentucky Medical Association.

Surviving are her husband, John Fraser; a stepdaughter Miss Carol Sue Fraser of Louisville; her mother, Mrs. Faye Belknap; brothers, Glen C. Morrison of Clendenin and Kyle H. Morrison of Oak Ridge, Tennessee; and sisters, Mrs. George Karabegles of Salerno, California, Mrs. Marcia Ward of Lynchburg, Virginia, and Mrs. Effa Mae Foster of St. Augustine, Florida.

* * * *

JAMES WILLIAM SKAGGS, M. D.

Dr. James W. Skaggs, 68, of Nitro, died on July 19 in Charleston Memorial Hospital after a brief illness.

A native of Hinton, Doctor Skaggs had practiced in Nitro for 44 years. He received his M. D. degree in 1920 from the University of Maryland School of Medicine.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Reba Virginia Sams Skaggs; a son, Dr. James W. Skaggs, Jr. of Philadelphia; three daughters, Mrs. G. P. Russell and Mrs. Dewey Mann, both of Nitro and Mrs. James Gerguson of Cincinnati; brother, Charles of Louisa, Ky.; and a half-sister, Mrs. R. Bruce Keifer of Washington.

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E. C. Vass, M. D.

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W. F. Park, M. D.
M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Haltrap, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
Roentgenology:
Evelyn Farester, R. T.

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County Societies

EASTERN PANHANDLE

The Eastern Panhandle Medical Society held its regular monthly meeting July 14 at The Shenandoah in Martinsburg.

Members of the Society decided to donate their services in giving physical examinations to boys and girls under the "Project Head Start" program.

Public funds appropriated for the examinations will be endorsed to a private charitable organization. The money will be used to help pay the cost of eyeglasses, dental supplies and other expenses in connection with the correction of physical defects.

Drug Abuse Control Law Explained In Pamphlet

The American Pharmaceutical Association has prepared a brochure for pharmacists and other health personnel outlining the requirements of the new federal drug abuse control law.

The publication is called "HR 2 and You." It presents highlights of the drug abuse control amendments of 1965 as they affect health practitioners. The brochure discusses drugs covered, federal registration, records required, inspection, samples, penalties and a check list of steps to be taken as of February 1, 1966, the law's effective date.

Single copies may be obtained free of charge by writing to the Association at 2215 Constitution Avenue, N.W., Washington, D. C. 20037. Quantity prices are: 25 copies, $2.50; 50 copies, $4; 100 copies, $6; 500 copies, $20; 1,000 copies, $35. Orders under $10 should be accompanied by a check.

Nurses Plan Convention

The annual convention of the West Virginia Nurses Association will be held at the Pleasant Point Resort in Point Pleasant, October 13-15.

Theme of the meeting is "Caring—Key to Action."

Two workshops for nurses are planned for September. A session on "Problems of the School-Age Child" will be conducted at the Holiday Inn in Charleston on September 24, and a "Geriatric Workshop" will be held at the Daniel Boone Hotel in Charleston, September 7-8.

Thoracic Society Meeting

The 1966 meeting of the American Thoracic Society will be held next May 23-25 in San Francisco in conjunction with the annual meeting of the National Tuberculosis Association.

Abstracts of papers should be submitted before January 6, 1966, to Dr. James Kieran, Chairman of the Medical Sessions Committee. Doctor Kieran's address is American Thoracic Society, 1790 Broadway, New York City 10019.

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The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning: If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Side effects
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Contraindications
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

Note: The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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Book Reviews

TODAY'S HEALTH GUIDE—Published by The American Medical Association and edited by W. W. Bauer, M. D., Director Emeritus, Department of Health Education. American Medical Association, 535 North Dearborn Street, Chicago, Illinois. 1965. Pp. 624. Illustrated. Price: $5.95.

"Today's Health Guide" is published by the American Medical Association as a health guidance for the American family. It is edited by W. W. Bauer, M. D., Director Emeritus of the Department of Health Education. It is compiled by more than 200 practicing physicians and specialists, dentists, clergymen, nurses, educators, safety directors, chemists, physicists and veterinarians.

The book is divided into 45 parts. In the first section, parental responsibility and community health services are stressed. It points out that the individual must first look to the home for health, and through the home learn about healthful patterns of living. The family is instructed on preservation of health in industry, nutrition, special care of teeth, eyes, nose, skin and throat. But while the individual is taught the advantage of the preservation of health he also learns that no "doctor book" can take the place of the doctor.

There are excellent descriptions of the human body and its functions accompanied by charts and illustrations, many of them in color.

In our present day emphasis on mental and emotional health, all members of the family will find Part IV highly instructive reading.

In the chapter on prevention of home accidents the danger of inside and outside tools is emphasized. Emergency first aid is described in words and figures that a child can understand. Dangerous and disabling diseases are presented in a manner that will save lengthy office explanations and give adequate background and understanding to the whole family concerning a large group of serious and critical illnesses.

Quackery and folklore are investigated and exposed in a readable manner. There is a long glossary of medical terms and a competent index making easy prompt reference possible.

This is not another doctors book that tells you how to avoid calling in a doctor, nor does it seek to promote self-prescribing. It is a valuable addition to the home library and to be used frequently by young and old.

The longer you are in the presence of a difficulty, the less likely you are to solve it.—Nicolle.

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Trocinate (Thiphenamil HCl) has been found in three clinical studies, (J. Mo. Med. Assoc., 48:685-6; Med. Rec. & Annals, 43:1104-6; J. Urol., 73:487-93), to be effective and to be free of side-effects. Fifteen years of wide clinical usage has affirmed the safety and effectiveness of Trocinate.

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Scholarships in Cardiology Established by AHA

Two teaching scholarships in cardiology have been established by the American Heart Association as an added step in its long-range program to improve further the level of medical education in the field of cardiovascular disease. Previously established and in effect since 1962 has been a program to support research in medical education through the award of special fellowships.

In its avowed aim to upgrade the status of full-time medical teaching, the AHA is now seeking candidates for the new teaching scholarships who "show promise of excellent future development or have proven ability as medical teachers," to encourage them to devote the major part of their efforts to teaching.

Each scholarship will carry a base stipend of $11,000 for the first year, with annual increments of $1,000 up to a maximum of $15,000. An additional grant of $1,000 per year will be made to the teacher's institution, to cover expenses for travel, minor items of equipment, or items for use in teaching.

Additional information and application forms may be obtained from Frederick J. Lewy, M. D., Director, Department of Medical Education, American Heart Association, 44 East 23rd Street, New York, New York 10010.

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CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patienrs with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chickenpox or susceptible persons exposed to it.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dicrare reduction of dosage of Arthralgen-PR.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953.

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Society	President		Secretary		Meetings
Barbaur-Randalph-Tucker	Ernest G. Guy	Philippi	A. Kyle Bush	Philippi	3rd Thurs.
Baane	Harald H. Hawell	Madisan	David E. Wallace	Madisan	2nd Wed.
Braake	W. T. Baaher, Jr.	Wellsburg	W. T. Baaher, Sr.	Wellsburg	
Cabell	W. R. Wilkinsan	Huntingtan	Harald N. Kagan	Huntington	2nd Thurs.
Central West Virginia	I. F. Hartman	Buckhannan	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	C. V. Tawnsend	Martinsburg	2nd Wed.
Fayette	D. Alene Blake	Oak Hill	W. P. Bittinger	Oak Hill	1st Wed.
Greenbrier Valley	Rabert G. Shirey	Lewisburg	Claude L. Hauck	Lewisburg	2nd Wed.
Hancack	J. L. Thampsan	Weirtan	Gearge S. Kasar	Weirtan	2nd Tues.
Harrisan	A. Rabert Marks	Clarksburg	James A. Thampsan	Clarksburg	1st Thurs.
Kanawha	Edward Jacksan	St. Albans	Jerill D. Cavender	Charlestan	2nd Tues.
Lagan	Lyle H. Bayea	Man	Kwan Ha Lee	Lagan	2nd Wed.
Marion	W. T. Lawsan	Fairmant	G. Thamas Evans	Fairmant	Last Tues.
Marshall	Kenneth J. Allen	Maundsville	J. W. Myers	Maundsville	3rd Tues.
Masan	C. Leanard Brawn	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Manthly
McDawell	J. Hunter Smith	Welch	David J. Skewes	Welch	2nd Wed.
Mercer	Sam Milchin	Bluefield, Va.	Jahn J. Mahaad	Bluefield	3rd Man.
Minga	Enach W. White, Jr.	Red Jacket	L. Lake Swigart	Williamsan	2nd Wed.
Manangalia	Gearge A. Curry	Margantawn	Wm. E. King	Margantawn	1st Tues.
Ohia	Warren D. Leslie	Wheeling	A. M. Valentine	Wheeling	4th Tues.
Parkersburg Academy	E. B. Halmes	Parkersburg	Delmer J. Brawn	Parkersburg	1st Thurs.
Potomac Valley	Beverly N. Chambers	Maarefield	Rabert W. Bess, Jr.	Piedmant	2nd Wed.
Prestan	Jahn W. Trentan	Kingwaad	C. W. Maser	Kingwaad	4th Thurs.
Raleigh	Warren D. Elliatt	Beckley	W. W. McKinney	Beckley	3rd Thurs.
Summers	Bufard W. McNeer	Hintan	Jack D. Waadrum	Hintan	3rd Man.
Taylar	Paul P. Warden	Graftan	Herbert N. Shanes	Graftan	Last Thurs.
Wetzel	Lemayne Caffield	N. Martinsville	Charles P. Watsan	N. Martinsville	Manthly
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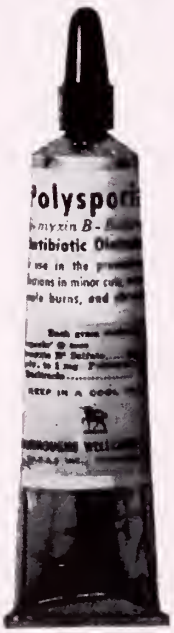

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The West Virginia Medical Journal

Vol. 61, No. 10 October, 1965

Presidential Address*

Albert C. Esposito, M. D.

Abraham Lincoln once said,
"Let us have faith, that right makes might,
And in that faith, let us to the very end,
Dare to do our duty as we understand it."

As I stand before you, exactly one year after taking the oath of office to become your 98th President, I have an even greater sense of humility after a year's experience in the responsibility of this office. It has been a privilege and an honor to serve you and organized medicine to the best of my ability, and I hope that I have continued the tradition of your many past presidents in this long chain of devotion to our profession.

I would have liked to talk to you philosophically at this time, but the moving events of this year and these past few months dictate otherwise.

This has been a busy year, filled with much hard work. It has also become the year of crisis for medicine; the die has been cast, the Rubicon crossed, and it may go down as the year of infamy for men of medicine.

We have suffered a great defeat, but let us remember it as a Dunkirk and not a Waterloo. The war will and must be continued! Those of us to whom you have entrusted the responsibility of leadership have tried to tell our true and honest story to our fellow physicians, to your wives, friends, and to our patients; but those in power in Washington, seemingly having sipped the heady wine of unbridled power and unmindful of the real wishes and desires of so many of their constituents, as proven by every public opinion poll, and acting as though at the beck and call of organized labor, the so-called liberals and the political influence of our national administration, have enacted into law, and it is a bad law, this monstrous socialistic scheme for medical care of the elderly, a plan which Senator Carl Curtis on the Senate floor called, "not only socialism—it is brazen socialism. This bill will tax people who cannot afford to be further taxed, and it will burden a government that cannot afford to be further burdened, in order to provide benefits for individuals, so many of whom are well able to provide for themselves."

Yes, as a French Philosopher so aptly said, "The American Republic will endure until politicians find that they can bribe the people with their own money."

National Legislation

In Congress, they are making plans for other far-reaching socialistic schemes—for instance, the regional center concept for research and treatment of heart disease, cancer and stroke, the recently passed Appalachia Bill, the poverty program and others to further ensnare medicine within this socialistic fold. Organized medicine has been trying to warn how these ill conceived and hastily written bills will totally disrupt our present concept of medical practice. Dr. Hugh H. Hussey, a member of the Heart Disease, Cancer and Stroke Commission representing the American Medical Association, resigned when he saw how the Commission was leaning. He stated it would take away sorely needed manpower from our present research centers, private practice, medical schools and teaching hospitals.

The Author

- **Albert C. Esposito, M. D., Huntington, W. Va., Immediate Past President of the West Virginia State Medical Association.**

*Annual Address of the President, West Virginia State Medical Association, 98th Annual Meeting, The Greenbrier, White Sulphur Springs, August 28, 1965.

Although we wholly support the idea of research and a reduction in the number of cases of these diseases, with the already passed Medicare whose impact on our hospitals, nursing homes, physicians, and medical personnel remains undetermined, we strongly urge additional detailed study of all of these proposals before Congress further enacts hastily written medical legislation. There is no emergency!

The Appalachia Bill which includes $41 million dollars to build multi-county demonstration health facilities, including hospitals, diagnostic and treatment centers, with funds to run these 100 per cent for two years and 50 per cent for three additional years, is an example of such hastily written legislation which is far reaching and socialistic in nature, but which was passed without advice or approval of organized medicine.

As we look at the national scene today, let us be ever mindful of the lessons history has carved in the annals of time. *For as Santagana so aptly noted, "Those nations that do not learn the lessons that history has to teach, will be condemned to relive them."*

History has recorded the rise and fall of Democracies with man's eternal desire for freedom, but as was written, "When Democracy's belly takes command of its head, then its days are numbered." Liberty and equality are ordained to wage war, with the Achilles Heel of each Democracy being the drive of the masses to use their mighty weapon—political equality—to impose an equality of economic gain or socialism—and thus lose the production incentive, which is so important to a democracy. This invariably leads to disaster. Over and over again as this has occurred, the stage has been set for the appearance of a national savior to rescue the people from these self-inflicted troubles and Democracy becomes a dictatorship. The controls become ruthless and rigid, leading invariably to anarchy, with its resulting great suffering—then the search and desire for liberty, freedom and democracy tends to rise again. We might well ask, will this be our fate?

It was Patrick Henry who so prophetically said, "Be extremely cautious, watchful, jealous of your liberty or this government will eventually destroy the state governments and swallow the liberties of the people."

As we survey the present situation, there is cause for alarm and we need to pause to consider the course of history as it is being set by this present socialistic-inclined and labor-controlled Congress, with its unrestrained spending. We know now, as Dr. Donovan F. Ward warned us, "that we were wrong when we thought the simple straightforward presentation of the truth would overcome the 'big lie'." We also know that our fight against the socialization of our profession and in turn our country was right 30 years ago, just as it remains right today. Never have so many physicians done so much to carry the truth to the American people, but are our citizens asleep or has some hypnotic spell been cast over them?

Thomas Jefferson, out of our glorious past said, "We must make a choice between economy and liberty or profusion and servitude. If we can prevent the government from wasting the labors of the people under the pretense of caring for them, they will be happy."

With H. R. 6675 signed into law, let us remember that organized medicine was given only 15 minutes to testify before the Senate Finance Committee as to our opinion of this law. Now, we hear the bleating of the sheep. We have Wilbur Cohen's statement that he is very desirous of having medicine's help and cooperation in the administration of this new law, but have we forgotten our experience with the UMW program. I ask you: did Mr. Cohen or the majority of the members of the two committees in Congress, who wrote this bill, try to enlist the aid of medicine in its formation—or did they listen as Senator Harry Byrd in his minority report pleaded, "Though the hour is late, it is never too late to do the right thing. Let us consult with our great medical profession and cease listening to the voices of government witnesses who throughout the world have sung the siren songs, which has resulted in *mediocre government quality medicine replacing a far better* system under which a free medical profession can continue to produce medical miracles for all of mankind."

We, as physicians, have always been for complete medical care for all our citizens regardless of ability to pay, a known policy that seems to have been forgotten or purposely overlooked.

Unity Within the Profession

That our foes have been successful up to this point can in part be attributed to the lack of unity and interest within the medical profession —the danger from within our ranks—this is our *greatest danger.* I urge you to read the resolution entitled, "Preserving the Freedom and Quality of Patient Care," as passed by your Council and as presented in the July 1965 issue of *The West Virginia Medical Journal.* Let me remind you of the disorganization and disunity of the

British Medical Association, as it was capitulated into Socialized Medicine as against the united and determined stand of the Australian physicians that set back the socialization of medicine there even after a law such as ours had been enacted.

You stand at the fork in the road—a true dilemma—and yet this could be the physician's greatest hour. One road leads down to complete subjugation and socialization. The other leads to a higher plane to uphold the traditions and heritage of the free practice of medicine. By the laws of our country, only you can really decide which road you may take.

Robert Louis Stevenson said it so well when he wrote, *"To know what you prefer instead of humbly saying amen to what the world tells you you should prefer, is to have kept your soul alive."*

In our historic struggle against socialism, we have had many allies and true friends, yet the majority of the communication media, radio, press and television were not in the vanguard of this fight. Strangely, now we find editorial press comment and some television and radio commentators telling the people what a bad law has been enacted—again, all this too late. I have felt that many of these media have been muzzled and not free to follow the old newspaper adage, "the truth and nothing but the truth," for at times they have acted as puppets paraphrasing socialistic doctrines and at other times, seemingly enjoying any allegation which would debase the physician image and refusing to tell, or even let us tell, time after time, of the dangers of this newly enacted bill, for fear of losing some viewers, listeners or circulation or possibly falling in disfavor with the administration; and yet the truth repeated over and over again would have strengthened the basic concept of freedom of the press, for which our forefathers fought so hard when founding this country. As time goes on, this loss of the freedom of the press will be another milestone in the decline of true democracy in America, for without a free and aggressive press, radio and television, able and willing to tell the truth, the fruits of democracy shall wither away and die on the vine.

Shortage of Physicians

There are many other problems which remain with us such as: the shortage of physicians both on the state and national level. Statistics show that the 84 medical schools in the United States graduated 7,336 physicians last year. There are 7,138 hospitals in the United States and 1,423 of these have approved educational programs with places for 12,229 approved internships. This means that only 79 per cent of the approved internships are filled—roughly 9,636 with 2,373 of these places being held by foreign graduates or remaining vacant. This is a serious problem and should concern us all.

Various solutions have been suggested but the primary need is for many more students to be graduated from our medical schools. Instead of closing these multi-million-dollar medical schools in the summer months, let us enroll another class of students to make this a year round scholastic program.

Our own four-year West Virginia University School of Medicine is doing a heroic task considering that it is only in its infancy; but it becomes all too clear that to meet the continued physician demands in this State, even the step just mentioned will not be sufficient. A present need for possibly a two year and later a four year school of medicine should be considered. I strongly recommend that it should be located in the area of the largest population in our state, namely the Charleston—Huntington area.

We consider the medical school as the center of medical research, education and service to our state with a faculty passing on the torch of medical knowledge to those who follow us, inspiring them to practice an even more scientific and proficient type of medicine, all to the end that those who are now students shall in turn, teach those who follow them in this endless chain of the heritage of medicine. With the enactment of H. R. 6675 into law, we must step up the recruitment of medical students if we are to survive.

Aid for Medical Students

We must share in the pride of continuing our Charles Lively Memorial Scholarship Fund to deserving students which permits them to study medicine in our West Virginia University School of Medicine. The two recipients of this year's awards will be presented to you later. This year, we have added, in addition to the two scholarships, a $4,000 dollar revolving emergency loan fund, which in time should be self-sustaining.

Also, in this past year, you gave $13,051.20 as voluntary contributions to the AMA-ERF and this in turn was given to the West Virginia University School of Medicine. I would urge in the years to come that the check be presented to the Dean of the School of Medicine before the House of Delegates, at the time of the annual meeting.

Over the years, we, in organized medicine, have endorsed and continually advocated the

acceptance of the concept of a combined Blue Cross and Blue Shield Health Insurance plan.

Separation of Blue Cross-Blue Shield Plans

It now becomes obvious that with the increasing spiral of hospital costs, which is averaging 10 per cent yearly, no longer does Blue Cross, the hospital plan, one of those in the Trojan Horse, reflect the thinking of organized medicine, as evidenced by its disregard of some of our basic philosophies and by its many utterances and testimony before various Congressional committees. I would, therefore, recommend to you that we reevaluate our endorsement of the National Blue Cross-Blue Shield system and try to explore means of separating the two plans and the feasibility of having our own Blue Shield, the doctor's plan, sold and serviced as a separate plan, not only statewide but nationally, to its subscribers.

The problem of the increasing cost of hospital care to our patients when coupled with the testimony and support given, like the Trojan Horse, by the American Hospital Association, to the recently passed H. R. 6675, gives us further concern. It is time we became concerned with each item on our patient's hospital bill—we should review these items and try to cut down any excessive costs. Whether we like it or not, the patient associates these high costs with his total medical bill and you, the physician, are blamed for them.

The role of the hospital as it assumes the conduct of teaching and scientific research in our communities, plus the many compulsory hospital meetings which must be attended by the already overworked physicians of our State, versus the non-compulsory county medical society meetings, must eventually be dealt with by the physician's organization.

If this present trend continues, it is not too difficult to see that collision may occur as to who shall eventually control the practice of medicine.

The private practitioners of medicine in our State, already overburdened, are manning the emergency rooms of many of our larger hospitals on a twenty-four hour rotation basis because of the previously mentioned lack of interns and residents. I am certain that the people in our communities know little of this sacrifice which their physicians are making in attempting to man and keep the emergency rooms of the community hospitals open.

A love and devotion to medicine is intrinsic in most every physician as he gives up many of his leisure hours for the unselfish and unpublicized devotion to charity, the free clinics, civic endeavors, medical research and additional study, so that he may be better able to care for his patients. It is all too well known by all of you—but has the communication media told this to the American people? Yet, our efforts to give the best of medical care and attention to our patients is being further hampered by some men in our national and state legislatures, who are strongly biased and ill-advised and whose only goal seems to be to undermine our present system of medicine and perpetuate themselves in power by catering to minority groups.

Justice Brandeis warned us with these words, "The greatest danger to liberty lurks in the insidious encroachment by men of zeal, who are well meaning but without real understanding."

I strongly urge the physicians in our State to be always alert, otherwise non-medical groups will also succeed in taking over the planning and operation of area wide health facilities and completely shut the physicians out of these activities both in their communities and throughout the State. I would recommend that we seek the formation of a Physician's Advisory Committee selected by this Association to the administration of all future Hill-Burton funds in our State.

In this past year, I have met with Governor Hulett Smith to discuss various legislative matters and there exists a most cordial relationship with this present State Administration. Many of our legislative goals have been achieved in this past session of the West Virginia Legislature and progress is being made with many of the problems presented by different departments of the state government, such as the Compensation and Welfare Departments. Your Medical Economics Committee, under the able direction of Dr. George R. Callender, Jr., and the Subcommittee under Dr. Harry S. Weeks, Jr., plus each member of this entire Committee, have done a yeoman's task this year and each is to be commended for a job well done.

We are quite proud to be able to tell you that the Welfare Department Fee Schedule for GMH and other services is to be revised to fit the fees of MAA and modified Blue Cross fees.

Yet, as we look back at our many years of dealing with third party fee schedules and in view of the national situation, I would ask you to consider rejecting all third party fee schedules and substitute our usual and customary fees for service in our various areas of practice.

Revision of Constitution and By-Laws

One of my first official acts of last year was to direct our Constitution and By-Laws Committee to bring our West Virginia State Medical Asso-

ciation Constitution and By-Laws up to date and make the necessary additions and deletions which the members of this Committee believed were necessary. We are happy to see that this has been completed and has been offered to you at this Convention and we are truly grateful to our faithful friend and Past President and Chairman, Dr. James S. Klumpp, and his Committee, for the outstanding work they have done on this assignment.

Throughout the year, I have mentioned to you our continuing financial crisis. Over these many years, in attempting to meet the demands of our profession, fighting socialistic legislation on state and national levels, and with an ever increasing cost spiral, our State Medical Association finds it has strained its financial resources beyond its limitations where it now becomes obvious that a dues increase is in order if we are to continue our struggle in these critical times. This is a serious problem which you Delegates must resolve at this annual meeting. I can assure you that your members of Council and your officers have considered this matter over and over again and the recommendation for a dues increase was made only after long and sincere study, review, evaluation and projection of future costs to maintain this Association so that it can continue to fight the further encroachment of government and socialism upon our profession in West Virginia. You may recall the fight to amend our medical practice act, to prevent the public corporate practice of medicine, to enact a good mental health bill, a medical examiner's system, a review and constant examination of the national and state fee schedules by various State Medical Association Committees; the review and evaluation of maternal and fetal health statistics, our Legislative Committee's screening of all pertinent bills in our Legislature and Congress, and our annual Rural Health Conference, which assumes a larger and important place in our making new friends for medicine. I could enumerate many, many other activities which are also some of the functions of your State Medical Association.

Purpose of the Organization

Let me remind you that a profession gains distinction from the character and achievements of its members and it acquires unity, strength, direction and purpose only by organization. Through your State Association, physicians develop and carry out numerous programs for the improvement of the profession and the betterment of the public health. These accomplishments on a state level make organized medicine act and react from a position of strength and can make its views known from one end of the State to the other. Without organization, the medical profession would become fragmented, lose its influence, its direction, its sense of purpose, and it would speak not with a loud, strong voice but with a confused babble to which few, if any, would listen.

As you consider the dues increase, let me again remind you of the need and may your action in this matter be prompted by what is best for medicine in West Virginia.

Never before has the individual physician been more needed in his medical organization and never has he needed it more than he does today.

The Future

As to the future, I would urge that the Budget Committee prepare a yearly budget and that some funds be set aside each year to plan for a future home for our State Medical Association. Possibly, the land site might be donated by members of the profession and a building later built there. This is not an impossible task, as our neighboring states who already have such a central office, acquired on this basis, can verify.

As each President surveys his year in retrospect, he must have a feeling of pride in the devotion which all of you, my fellow physicians, show as you daily practice this greatest of professions—medicine.

To the Committee Chairmen, each member of the Committees and each and everyone of you, as you work for medicine, I am grateful. To those who are members of Council and your officers, whose devotion is above and beyond the call to duty, there is much that could be said. Your Council and officers have worked hard in this past year and yet as the future unfolds, I would recommend to you that Council should meet every second month, excepting for the winter months of the year, in order to consider at a more leisurely pace, the many problems presented.

I would recommend that in the critical months ahead, when communication and cooperation shall be vital, that steps be taken in each county medical society to make their Councilor to the West Virginia State Medical Association a member of their county medical society executive committee.

Role of the Auxiliary

Our Auxiliary has been a constant source of aid and enthusiasm in this past year. They have willingly worked on their many assigned tasks under the able direction of Mrs. George A. Curry. That they are our ablest and strongest sup-

porters, none here can doubt. Yet, are we their strongest supporters? They are truly devoted to our cause. I would ask each of you and your component medical societies to find ways to aid the Auxiliary financially to the utmost of your ability. The American Medical Association has gone on record asking that we explore possible means of including the Auxiliary dues with ours. The Auxiliary's projects are only what we, in medicine, deem necessary and I firmly feel that some way should be found to eliminate their annual registration fees at this meeting and to give them a more liberal allowance for their annual convention activities. They are truly doing a magnificent job in telling our story which you, the members of organized medicine, haven't the time to tell. God bless our Auxiliary.

In conclusion, let me remind you that our responsibility to our patients and our community no longer ends at the door of our consultation room.

I urge each of you to become an active member of our State WESPAC to insure that freedom remains in the practice of medicine. I know a jungle of apathy has been present toward WESPAC in our State, but after Doctor Annis' most eloquent presentation, I hope it hit responsive ears and that each physician and his wife will join WESPAC. It is true that we were taught to fight a war on disease at medical school, but out of necessity and not of our own choosing, we have been flung into the political wars. Let us resolve to participate in our community's affairs, as well as our medical and political organization's functions, with a determined unity of purpose and action as we face the difficult times that lie ahead.

In these months ahead, decisions affecting the future practice of medicine are to be decided. At no time in our history have we needed the unity and leadership which is so urgently needed at this time, for remember only in unity do we have strength.

Let us continue our established practice, as we have in the past, to help those in need and to be continually guided by the creed of "Doing what is best or good for medicine in West Virginia." Remember our State's Motto, "Montani Semper Liberi—Mountaineers Are Always Free." May God Always Keep Us That Way.

I thank you.

Perforation of the Gallbladder in the Aged

Manuel C. Vallejo, M. D., and H. G. Dickie, Jr., M. D.

PERFORATION of an acute suppurative gallbladder is not frequent. The mortality rate in untreated cases of acute perforation with bile peritonitis is 100 per cent. Resolution occurs in approximately 90 per cent and perforation occurs in approximately 10 per cent of cases of acute cholecystitis. Perforation[1] of a gangrenous gallbladder is five times as frequent in the older age group as in the younger. Acute calculus cholecystitis is the leading cause of perforation or rupture of the gallbladder. Acute noncalculus cholecystitis[2] may account for 5 per cent to 10 per cent of all reported cases of acute cholecystitis.

There is no other part of the body in which disease conditions may be so out of proportion to the symptoms as the part involved in cholecystic disease. Many authors have emphasized the lack of correlation between clinical manifestations of gangrenous cholecystitis and the severity of the pathologic findings. Behrend and Gray[3] reported discrepancies between clinical and pathologic findings in 59 per cent of 200 cases of acute cholecystitis. There is little upon which to base a diagnosis of impending perforation of the gallbladder; correct diagnosis, therefore, is made infrequently. Bachuver, Deeb and Taylor[4] found 32 cases of gangrene with perforation of the gallbladder at autopsy. In only 50 per cent of the cases was the diagnosis made prior to post mortem examination.

Early signs and symptoms of acute cholecystitis in the aged patient are more obscure than in the younger. In contrast to that in the young, the course of the disease in the aged is unpredictable, with greater likelihood of progress into complications. With the rapid increase in the aging population there is a corresponding increase in hospital admissions of the sick elderly with coexisting abnormalities including all types of cardiac dysfunction and pulmonary, cerebral, renal, hepatic, nutritional and metabolic diseases. These factors will distinctly influence the diagnosis, management and prognosis of actute cholecystitis and its complications in the aged. Interest in the subject was stimulated by experience with 3 cases in male patients over 70 years of age during the past five years. All three patients presented acute inflammation of the gallbladder, with stones and perforation at operation. All recovered following cholecystostomy (in 2 cases) and cholecystectomy (in one case).

Submitted to the Publication Committee, April 8, 1965.

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Case Reports

Case 1. W.P., a 95-year-old white man, was admitted on December 29, 1964, complaining of urinary urgency. On December 31, 1964, he complained of vague, right-sided abdominal pain. There was no rebound tenderness nor rigidity. Bowel sounds were present.

On January 1, 1965, there developed abdominal distention, rebound tenderness and rigidity throughout the abdomen but more marked in the right upper quadrant. No mass was palpable and bowel sounds were faint. The patient's pulse varied from 78 to 88 per minute. Temperature (oral) was 97.8 °F. Flat plate of the abdomen was normal. White blood cells 16,623, segmented neutrophils 94 per cent, nonsegmented 1 per cent, lymphocytes 3 per cent, monocytes 2 per cent, hemoglobin 13.6 Gm., hematocrit 45 volumes per cent.

The impression of acute cholecystitis was recorded and mesenteric thrombosis as a second possibility was entertained. A Levine tube was inserted and connected to Wangensteen suction for decompression. He was placed on Chloromycetin and intravenous fluids, a liter each of 5 per cent glucose in water and 5 per cent glucose in normal saline.

At operation, a thick gallbladder with a perforation at its cystic ampulla was seen. The peritoneal cavity was filled with dark green bile. Small stones of varying size were removed and a large rubber tube inserted into the gallbladder. No pathology was noted in the pancreas, common duct or duodenum. The peritoneal cavity

was irrigated with saline solution and the abdomen drained with a Penrose drain.

His postoperative course was slow but progressive. Bile drainage was clear and scant. The cholecystostomy tube was removed on January 20, 1965. Except for frequency of urination the patient was fully recovered when discharged on February 2, 1965.

Case 2. S. H., a 75-year-old white man, entered the hospital on September 24, 1960, because of severe epigastric pain, nausea and vomiting of 24 hours' duration. There was a 12-year history of peptic ulcer not proved by barium study. The patient appeared acutely ill. Blood pressure was 150 systolic and 60 diastolic, pulse 98, respiration 30 and temperature 98.4 F. (orally). The abdomen was moderately distended, with marked tenderness and board-like rigidity in the mid-epigastric region. There was no palpable mass. Bowel sounds were absent.

Hemoglobin was 17 Gm., white blood cells 21,350, segmented neutrophils 79 per cent, nonsegmented 7 per cent, lymphocytes 14 per cent. Urinalysis revealed albumin (3 plus), a trace of sugar and pus (3 plus). Chest and abdominal x-rays showed elevation of the right hemidiaphragm. An admitting diagnosis of perforated duodenal ulcer was made.

At operation, three hours after admission, a partially sealed perforated duodenal ulcer was seen. Just opposite the ulcer was a perforation of the midfundic portion of a gangrenous gallbladder containing stones. Bile and gastric leakage were minimal. The entire area was sealed off by omentum. The stones were removed from the gallbladder and a large cholecystostomy tube inserted. Omental tags were laid over the duodenal perforation. After a careful toilet of the abdomen a Penrose drain was left in Morison's pouch.

The patient's postoperative course was uneventful except for urinary retention secondary to prostatic hypertrophy. Electrolyte No. 3, 1,000 cc's. twice a day, Chloromycetin 1 Gm. twice a day for 12 days and Levine tube decompression were the mainstay of treatment. He was discharged on October 13, 1960, on a special ulcer diet and antacids.

Case 3. S. Z., a 73-year-old overweight white man, was admitted to the hospital on October 9, 1963, with generalized abdominal pain. Twenty-four hours before admission, he had noticed right upper quadrant pain which later had become generalized.

The blood pressure was 130 systolic and 90 diastolic, pulse 98 and temperature 97.4 F. (orally). There was pain all over the abdomen, with moderate rebound tenderness and rigidity in the right upper quadrant. Bowel sounds were absent. Hemoglobin was 15.6 Gm., white blood cells 29,804, segmented neutrophils 94 per cent, nonsegmented 3 per cent, lymphocytes 2 per cent, monocytes 1 per cent. A flat plate of the abdomen showed an adynamic ileus. The preoperative diagnosis was acute cholecystitis with possible perforation.

Four hours later, operation was carried out. A perforation was noted in the fundus of the gallbladder; the latter was large and gangrenous and contained stones of various size. One stone was impacted in the cystic duct, producing complete obstruction. The common duct and pancreas appeared normal. Bile in the peritoneal cavity was aspirated and cholecystectomy performed without difficulty.

On October 13, 1963, the postoperative course was complicated by evisceration. The wound was closed with silk and nonfilament nylon retention sutures. Convalescence was slow but progressive. At the time of discharge, November 16, 1963, the wound was healed.

Discussion

The three cases reported carry the features of perforated acute calculus cholecystitis in the aged. The obscure early signs and symptoms of an impending perforation in the older age group further magnify the problem of early recognition of the complication. In only one of the three cases was a perforation suspected preoperatively although acute cholecystitis was the preoperative diagnosis in two. It is the purpose of this paper to arouse diagnostic awareness of the disease and its fatal complication if unrecognized.

The pathologic changes leading to gangrene and perforation usually are the result of a stone having lodged in the cystic duct[2] so that the outflow of bile is prevented. This was nicely shown in Case 3. As a result of a blockage and edema there is thrombosis of the venous return and eventually the arterial supply, with early ischemic necrosis and perforation following. In the aged patient,[5] the process ordinarily takes place with much greater violence than is the case in the younger patient and may lead to serious complications and early death. The most frequent site[2] of the process is the fundus of the gallbladder. In two of the three cases reported, the perforation was fundic.

Perforation of the gallbladder as a complication of acute cholecystitis may occur in any one of the following ways: (a) into the peritoneal cavity, (b) into an adjacent hollow viscus, form-

ing a fistulous tract and (c) about the gallbladder bed, forming a pericholecystic abcess. Fletcher and Ravdin,[6] in a series of cases of perforation of the gallbladder reviewed in the literature, found that perforation after the manner described under (a) ocurred in 29 per cent, after that described under (b) in 19 per cent and under (c) in 52 per cent. Extravasation of bile[7] into the peritoneal cavity has been shown to be almost always bacterial because of the rapid invasion of anaerobic organisms from the liver. This apparently is the chief cause of death, more so in the aged, although the shock resulting from the chemical irritation also is a factor. Bile causes a marked capillary and venous engorgement of the serous surfaces resulting in a large exudation of fluid estimated by Harmon and Hudson to be approximately one-third of the total blood volume. Fortunately, perforation of an acutely inflamed gallbladder more frequently results in local rather than a diffuse peritonitis. The latter complication occurs only rarely except in the late, badly neglected cases after repeated attacks of acute inflammation.

The patient with acute cholecystitis has pain, tenderness and frequently a palpable mass in the right upper quadrant of the abdomen. In many instances, gangrene and perforation present the same signs and symptoms. According to Strohl[2] and his associates, the most helpful factor in the diagnosis of these cases is evidence of progression of the disease, manifested by a rise in pulse rate, enlargement of the mass in the right upper abdomnial quadrant and marked increase in tenderness to palpation. When bile peritonitis follows inflammation and perforation of the gallbladder, there is abrupt worsening of the patient's condition. In none of our three cases of perforation was a mass palpable in the abdomen but there was evidence of progression of the disease in all. Acute cholecystitis in the aged may occur with easily recognized signs and symptoms. It may develop insidiously or with violence.

It is interesting to note that there seemingly is an increased incidence of acute cholecystitis whenever aged patients are forced to be recumbent for several days. Glenn[8] reported perforation of an acutely inflamed gallbladder in hospital patients under observation for an entirely unrelated condition. Allen and Wallace[9] reported 30 cases in which perforation occurred while the patient was under observation in the hospital. In Case 1 of our series the patient was treated for prostatic obstruction when perforation developed. In Case 2 there was an admitting diagnosis of perforated duodenal ulcer, proved at laparotomy, with perforation of the gallbladder as an incidental finding. The occurrence of these two separate primary complications in one case was believed to be the result of gross duodenal ulceration and a gangrenous gallbladder filled with stones seen at laparotomy.

A leukocyte rise above 20,000 per cu. mm. or a differential white blood cell count showing a relative proportion of polymorphonuclear cells of 90 per cent or more is suggestive of actual or impending gangrene with perforation and complications. It should be remembered, however, that gangrene can occur in the presence of a normal leukocyte count with a normal differential count. The differential count was of little significance in demonstrating the presence of perforation in Strohl's[2] series. The count was over 20,000 per cu. mm. in 50 per cent of cases of perforated gallbladder. In the remaining half the leukocyte count was within normal limits. The patients in two of our three cases of perforation had counts over 20,000 per cu. mm., with proportional polymorphonuclear leukocytosis of over 90 per cent.

A cholecystogram is of limited value in establishing the diagnosis of acute cholecystitis because an acutely inflamed gallbladder is unable to concentrate any of the dye. The dye is unable to enter the organ because the cystic duct or ampulla is obstructed due to edema and inflammation. A plain scout film of the abdomen should be employed in these cases as it may occasionally reveal a radiopaque stone or the presence of gas in the gallbladder or biliary tree, or both. Of 121 flat plates for gallstones in cases of proved acute cholecystitis at the Presbyterian Hospital in New York, 46 per cent positive scout film findings were reported by Smith.[10]

More Aggressive Treatment for Aged

The aged patient suffering from acute cholecystitis must be treated more agressively to prevent perforation. In no circumstances should there be delay in operating once the best possible physical condition has been attained. The few hours necessary to bring the patient into a more physiological state may mean the difference between a host of complications, with death, and a smooth postoperative course, with rapid recovery. Signs of generalized peritonitis call for surgical intervention as soon as the patient's condition permits. Attention should be focused on depletion of water stores, sodium, chloride and other electrolytes, protein, carbohydrate, and oxygen-carrying red blood cells. Special care must be taken to avoid overloading the system with water and electrolytes in elderly patients who have a compromised cardiac or pulmonary

reserve. The matter of early or delayed operation in cases of acute cholecystitis continues to be one of wide debate. It is believed from experience gained, however, that if an operation can be performed within 24 to 48 hours of the development of acute cholecystitis, it will result in a considerable saving of time, pain and expense, and the risk involved is not as great as that of acute perforation. There is no question, however, that the majority of surgeons are advocating early operation in the case of acute cholecystitis. In dealing with the aged, the simplest procedure that will handle the surgical problem is the best one. Although cholecystectomy is the procedure of choice for acute cholecystitis and cholelithiasis, the very old, debilitated patient with an acutely distended gallbladder is most safely treated by cholecystostomy. It may prove to be life-saving in the presence of fulminating infection of the gallbladder, particularly in the aged. Having undergone this procedure and after the infection has subsided, the patient is in better physical condition and the over-all mortality in the aged or poor risk patient will be lowered. Mahorner and Becker[11] performed cholecystostomy without mortality in the cases of 5 seriously ill patients whose ages were respectively, 90, 85, 83, 80 and 75 years. Glenn and Hays[12] reported no mortality in a group of aged patients who underwent cholecystectomy as an elective procedure following cholecystostomy performed during an episode of acute cholecystitis.

Summary

Three cases of acute perforation of the gallbladder in which the patients' ages were 95, 75 and 73 years, respectively, are reported. At operation, all three presented acute inflammation of the gallbladder, with stones and perforation. In only one case was perforation of the gallbladder suspected preoperatively. In one case a perforated duodenal ulcer and a gangrenous gallbladder with perforation and stones were found simultaneously at laparotomy. Two patients had leukocyte counts above 20,000 per cu. mm. Cholecystostomy was performed in two cases and cholecystectomy in the third. In the latter case evisceration occurred on the fourth postoperative day. In all three cases the patient recovered.

The pathogenesis, signs, symptoms, diagnosis and management of acute perforation of the gallbladder are discussed. A brief review of the literature is given.

Signs and symptoms of an impending perforation of the gallbladder in the aged may be obscure and the course of the disease unpredictable. The sick elderly usually has coexisting abnormalities which include all types of cardiac dysfunction, also renal, pulmonary, hepatic, cerebral, nutritional and metabolic diseases. It is in this age group that physicians and surgeons alike should be watchful for signs and symptoms of gallbladder disease. It is urged that careful and frequent observation of the elderly patient with abdominal pain be practiced and that diagnostic awareness of gallbladder disease and its complications be maintained.

References

1. Becker, W. F.: Perforated Gallbladders, Editorial, Surg., Gynec. & Obst. 105:638, 1957.
2. Strohl, E. L., Diffenbaugh, W. G., Baker, J. H. & Cheema, M. H.: Gangrene and Perforation of the Gallbladder. Internat. Abstr. Surg. 114:1, 1962.
3. Behrend, A. & Gray, H. K.: Acute Cholecystitis: Problems Created by an Attempt to Correlate Its Clinical and Pathological Manifestations, Surgery 3:195, 1938.
4. Bachuver, C. A., Deeb, P. L. & Taylor, E. A.: Gangrene and Perforation of the Gallbladder, Am. J. Surg. 67:40, 1945.
5. Zefrin, S. E.: Management of the Aged Surgical Patient, Year Book, 1957.
6. Fletcher, A. G., Jr. & Ravdin, I. S.: Perforation of Gallbladder, Am. J. Surg. 81:178, 1951.
7. Walters, W., Butt, H. R., Remine, W. H. & Priestly, J. T.: Surgery of the Biliary System, The Practice of Surgery, Lewis, Vol. 7, Chapter 2.
8. Glenn, Frank: Acute Cholecystitis Following Treatment of Unrelated Disease, Ann. Surg. 126:411, 1947.
9. Wallace, R. H. & Allen, A. W.: Acute Cholecystitis, Arch. Surg. 43:726, 1941.
10. Smith, B. C.: Acute Cholecystitis: Surgical Treatment of 323 Cases at Presbyterian Hospital, New York, 1932-1941 Inclusive, Surg. Clin. North America 25:285, 1945.
11. Mahorner, H. & Becker, W. F.: Acute Cholecystitis: Optimal Time and Extent of Operation, Am. Surgeon 27:347, 1961.
12. Glenn, F. & Hays, D. M.: The Age Factor in the Mortality Rate of Patients Undergoing Surgery of the Biliary Tract, Surg., Gynec. & Obst. 100:11, 1955.

Special Article

Syphilis Eradication Program in West Virginia: Role of the Practicing Physician

N. H. Dyer, M. D., M. P. H.

The West Virginia State Board of Health recently promulgated a regulation requiring the reporting of reactive tests for syphilis to the West Virginia Department of Health. Passage of this regulation fills a need voiced in 1961 by the Special Task Force Committee's report on syphilis to the Surgeon General, Public Health Service. West Virginia thus becomes the twenty-fourth state to adopt such reporting requirements.

Numerous national medical groups, including the American Medical Association, have endorsed and urged cooperation of private medicine in supporting the programs recommended by the Special Task Force on syphilis. The need for renewed emphasis in syphilis control is manifest by continuing increases in reported cases of infectious syphilis occurring nationwide in all social and racial groups.

The purpose of this article is to present the status of the infectious syphilis problem in West Virginia, and the programs designed to combat it. Contrary to oft-voiced negative concepts from individuals in public as well as private medical capacities, syphilis eradication in the United States is entirely feasible when we consider that the diagnostic and treatment tools are currently available to make this a reality.

Simply treating and forgetting a case of infectious syphilis, however, as is so often done, will most assuredly perpetuate the survival of the disease and guarantee its increase. This lesson was emphatically learned following the introduction of penicillin therapy in syphilis management in the 1940s. By 1957, new cases of infectious syphilis had declined to a nationwide low of 6,251 compared to more than 100,000 cases occurring annually before mass treatment with penicillin became routine. Since the efficacy of penicillin therapy moved the treatment of syphilis from public clinics to the private practitioner's office, however, cases become lost to epidemiologic follow-up. Consequently the disease has made a resurgence to over 20,000 new cases reported annually since 1962.

Submitted to the Publication Committee, August 1, 1965.

The Author

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The eradication of syphilis, very simply stated, will depend on the degree of case interviewing and contact investigation of cases as they occur. This means that until private practitioners not only treat and cure their patients, but also report them and permit them to be interviewed in order that the source and all spread cases can be determined and treated, syphilis will remain the threat and the problem that it has been historically. Epidemiology is an aspect of syphilis management that has been too often overlooked or suspiciously ignored by private medicine.

It is time we faced up to this responsibility: syphilis epidemiology is a public health procedure that has enjoyed unqualified success when utilized, but the need remains for the cooperation of every private physician if this joint public and private medicine approach is to succeed. Public health repeatedly has asked for help; we cannot afford to continue to offer only one hand when two are needed.

Results of Syphilis Epidemiology

To illustrate the success of the procedure, let's look for a minute at some results of syphilis epidemiology. Over one-third of the cases of primary and secondary syphilis reported during the past year in the United States were brought to treatment as a result of being named as sex contacts to infectious syphilis. In addition, an estimated 10,000 additional contacts who were negative for syphilis upon first examination were treated, thus insuring that those among this group (studies show roughly 10 per cent) who

were incubating the disease at the time would not subsequently develop it.

The West Virginia State Department of Health has carefully selected and highly trained venereal disease field epidemiologists, who have been performing syphilis epidemiology in West Virginia for over 10 years without a complaint as to violation of privileged information or confidentiality. These men are cognizant and appreciative of the trust and responsibility inherent in the doctor-patient relationship; they are aware of the psychological and emotional ramifications attendant with patients having a venereal infection; they are trained to recognize and protect all family and social implications; and they are, above all else, pledged to discretion and confidentiality when dealing with a venereal disease patient.

Every case of venereal disease or reactive laboratory test for a venereal disease reported to the State Department of Health is held in the strictest confidence. No follow-up of a reported case or reactive test is ever performed without the expressed knowledge and consent of the attending physician. All reports are accessible only to qualified personnel; they are not subject to subpoena or inspection by any court or agency. The safeguards and control measures applied to venereal disease patients and their suspects as practiced in West Virginia are beyond reproach. Why then can any physician hesitate to report? Reporting of venereal disease cases is required under Article 4 of the Public Health Laws of West Virginia. Thus, reporting of a venereal disease to the State Department of Health is not only legally and ethically sound but is, in fact, morally demanded.

The Patient and Results of Epidemiology

Regarding the patient and the results of epidemiology, the following general observations will usually apply:

(1) In spite of the typical patient's plea to a physician for anonominity and that he paid for his medicine, the patient does not really expect a physician to dishonor his obligation and not report the case.

(2) Regardless of the initial story the typical syphilis patient ordinarily tells the physician (usually an unknown pickup or prostitute fabrication), trained epidemiologists will invariably ascertain the source of the infection, and quite often identify additional spread cases.

(3) In spite of a patient's apprehension or even hostility initially exhibited towards the interviewer, these trained epidemiologists will reassure and put at ease the patient and overcome his misgivings and misconceptions. The patient in almost every instance is grateful for the opportunity to help.

No physician is really faced with a dilemma as regards case reporting because:

(1) The patient can truthfully be reminded that all physicians are bound by law to report every case of syphilis, as he is bound to report a gunshot wound or a case of smallpox.

(2) The patient can also be told that since all laboratories are required by law to report reactive tests for syphilis, the health department already has previous knowledge of his condition.

(3) If the diagnosing physician decides that no one should speak to his patient, this request will in every instance be honored.

This paper is an attempt to lay the cards on the table. It is a personal appeal to every physician to immediately report every case of infectious syphilis that you might treat. Each case you diagnose must be considered by you to be an urgent medical emergency that must be epidemiologically exploited without delay. It is the one unreported case that is so vitally significant to ultimate syphilis eradication. We realize that the scattered cases you treat must appear insignificant, but their importance increases when note is taken of the fact that most of the infections syphilis diagnosed by private sources in the United States is treated by physicians that treat only one to three cases a year.

With your participation in a team effort the prospects for syphilis eradication in West Virginia are excellent. We are confident that once physicians understand syphilis control procedures, and the need for reporting, there will be no hesitancy to report. When this occurs, and the time should be now, syphilis can be added to the list of communicable diseases that no longer are an affliction to citizens of the United States.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
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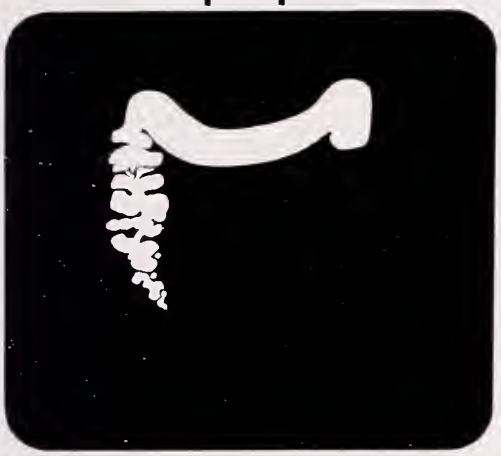
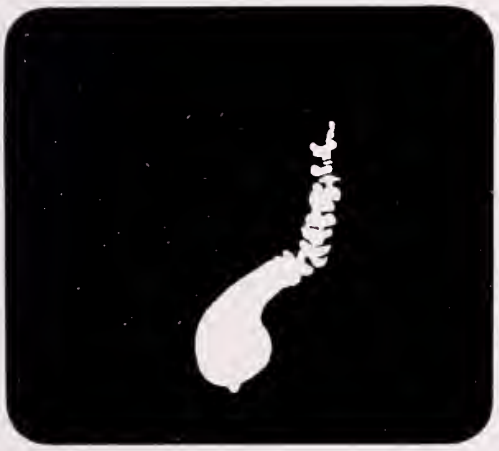


relieves distress

stops diarrhea



Precautions: Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses,* until diarrhea is controlled, are:

Children:

3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults:

20 mg. (2 tsp. 5 times daily or
2 tablets 4 times daily)

**Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

The President's Page

DOCTOR WANTED

A baby cries in the night—a doctor's wanted. A doctor dies and leaves his community without medical service—a doctor's wanted. A new industry looks at a town for a factory site—but a doctor's wanted. An emergency auto accident case arrives at the hospital without interns—a doctor's wanted.

This presents the problem. What is medicine's answer? None of our overworked doctors needs to be told that there is a problem. It has been with us for years and it is getting worse. With more demands facing us in the near future with the passage of unwarranted and ill conceived socialistic medical schemes, who will receive the blame? Why don't you doctors do something about it?

The problem is obvious. The solution is difficult—but let's get on with the task. As your President, I challenge each and every doctor, each County Medical Society and its Auxiliary, to give this matter your most serious attention. Meet and analyze your local problems. I am asking our Rural Health Committee to spearhead and coordinate our attack on this crucial problem. Communicate your thoughts and plans to Dr. Martha J. Coyner of Harrisville, Chairman of this Committee.

Project ADAM

And God said, "Let us make man in our image." Let us take Adam as our image, and from this let us project our plan *ADAM*—*A*dditional *D*octors *A*dvance *M*edicine. This is a positive plan, not a negativistic scheme of socialistic planners. Another adaption of *ADAM* could be *A D*octor *A M*onth. This goal is reasonable and with united planning and coordinated effort it can be doubled or tripled.

In order to mount a many-pronged attack, all available allies vitally interested in this problem will be contacted and their active support will be solicited, both at the state and local level. I feel that we need the support of such organizations as the West Virginia University School of Medicine, the West Virginia Farm Bureau, Cooperative Extension Service of West Virginia University, The West Virginia Home Demonstration Council, the West Virginia Bankers Association, the West Virginia Association of Realtors, the West Virginia Industrial Development Association, Area Development Associations, and governmental agencies having a responsibility in the area, such as the State Health Department, Medical Licensing Board and others.

The primary responsibility will rest with the County Medical Societies. They can make this project successful. The measure of success of this project will largely correspond to the amount of effort that is organized at the local level.

Seigle W. Parks, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

THE NEW PRESIDENT

Dr. Seigle W. Parks has placed into high gear his plans to promote a closer working relationship between officers and committees on the state and local levels. He stated at the outset of his term of office as President that he believed the State Medical Association existed to serve the county medical societies. He expressed the hope that he could visit every component society to obtain a better understanding of problems facing practicing physicians throughout the State.

During the month of September, Doctor Parks paid official visits to four component societies and several more are scheduled in October. Also, he has represented the Association at a number of regional and national meetings during the past four weeks.

A busy schedule is not new for Doctor Parks. In addition to an active private and industrial practice in Fairmont for more than 20 years, he devoted much time to his church and medical and civic affairs. Since moving to Charleston last January to accept appointment as Medical Director of the Chesapeake and Potomac Telephone Company of West Virginia, the pace has been accelerated.

His services to organized medicine through the years have been many and never once has he declined when called upon to serve the medical profession in one way or another. We are fortunate to have as President a man who is dedicated to his fellow citizens and colleagues.

Seigle W. Parks, M. D.

A son of a physician, Doctor Parks was born in Middlebourne, Tyler County, and was graduated from West Virginia University. He attended the two year WVU Medical School and received his M. D. degree in 1939 from the University of Maryland School of Medicine. He interned and served a residency at St. Agnes Hospital in Baltimore.

He served for four years in the Medical Corps of the U. S. Army during World War II. He served as Executive Officer of the 432nd Medical Battalion from 1942-44, when he was named Commanding Officer of the 55th Medical Battalion in Bamberg, Germany. He was released in 1946 with the rank of Major.

Doctor Parks served a term as President of the Marion County Medical Society and is a past president of the West Virginia Chapter of the American Academy of General Practice. He served for eight years as editor of "Mister Doc", official publication of the Chapter, and currently is serving as one of the two West Virginia delegates to the AAGP. He was honored this year by the AAGP by being named Chairman of the Committee planning the scientific program for the 1966 meeting in Boston. Doctor Parks served two terms as a member of the Council of the West Virginia State Medical Association and was elected Vice President in 1963 and President Elect in 1964.

He is married to the former Eleanor Hastings, who is a past president of the Woman's Auxiliary to the State Medical Association. They have three children: Eleanor Louise, a graduate of Denison and Stanford Universities who is now teaching school in California; Charles Langfitt, a senior at Ohio Wesleyan; and Margaret Ann, a senior in high school.

We are sure that Doctor Parks will have the active support and cooperation of physicians during his term of office and we are looking forward to his capable leadership during the coming months.

SYPHILIS PROBLEM IN WEST VIRGINIA

A great deal has been written in recent years about the extent of the infectious syphilis problem. Usually the reasons and excuses for the continuing increases have conveniently been attributed to various sociological factors. But with under reporting of syphilis by physicians as widespread as all evidence indicates, then much of the responsibility for the increase must rest on the shoulders of the medical profession for their failure to report their private patients so that control measures can be applied. The article on syphilis in this issue of *The Journal*, which bears the endorsement of the Syphilis Committee of the West Virginia State Medical Association, touches a nerve too many physicians have chosen to ignore. It certainly seems paradoxical that the means of eradicating syphilis is now known, but the will to overcome this historic scourge of man and medicine through the full cooperation of the medical profession in implementing the means is lacking.

The extent of the severe under reporting of venereal disease cases in West Virginia is alarmingly revealed in a recent survey of physicians sponsored by the American Social Health Association in cooperation with the American Medical Association. This study revealed that only about thirty-five per cent of the total cases of syphilis treated by physicians in West Virginia were reported to the Health Department. Figures for the infectious stages of syphilis and for gonorrhea were even lower.

The failure to report infectious syphilis cases no doubt can be traced either to the apathy of the physician or to his personal rationalizing of responsibility to patient versus his responsibility in a public health sense. Considering, however, that an isolated case of syphilis in an infectious stage is a contradiction, the failure to report a case and thus by default fail to provide for the well-being of the source host can hardly be justified either by physician indifference or by an arbitrary values decision by a physician based on emotion or subjective reasoning.

Failure to report latent syphilis cases of long duration is easier to understand but equally as unrealistic to defend. The State Department of Health is not interested in playing a type of numbers game where total morbidity figures are all important. Among other reasons, all cases of syphilis should be reported in order that a documented record of treatment can be maintained in the State VD Central Registry on all persons in the State treated for syphilis. Often, of course, adequately treated patients will retain reactive serologic syphilis tests for life. This registry is an invaluable source of information to physicians who are not sure of a patient's previous syphilis history or treatment.

Last month, the AMA began a nationwide campaign designed to curb the spread of venereal disease with an appeal to state and local medical societies to join the campaign. To their appeal and to Doctor Dyer's appeal in this issue —for physician cooperation and participation in a team effort with public health to eradicate syphilis—we wholeheartedly lend our endorsement.

THE HISTORY OF MEDICAL EDUCATION IN WEST VIRGINA

A book, "The History of Medical Education in West Virginia," published by the West Virginia University Library is now available. The authors, Edward J. Van Liere, Ph. D., M. D., Dean Emeritus and Professor of Physiology at the School of Medicine of West Virginia University, and Gideon S. Dodds, Ph. D., Emeritus Professor of Microscopic Anatomy and Embryology, need no introduction to the medical profession of the State. Doctor Van Liere became Professor of Physiology in 1921 and served as Dean of the School of Medicine from 1935 to 1961. He will retire in June, 1966. Doctor Dodds, now in retirement, taught in the School of Medicine from 1918 to 1951. For many years he served as Secretary of the School of Medicine faculty and Chairman of the Admissions Committee.

The book traces the development of medical education in West Virginia from 1869, when the first classes of anatomy and physiology were taught by Dr. Hugh Brock of Morgantown, up to the present time. Since the authors of the book have been associated with the School of Medicine of West Virginia University so long they were in a position to write an authoritative account of medical education in the State. This book will not only be of interest to the citizens of the State, especially physicians, but will also be a valuable addition to the history of medical education in the United States.

The senior author, Dr. Edward J. Van Liere, has been a member of the Editorial Staff of *The West Virginia Medical Journal* for 23 years. He has contributed many scientific articles to *The Journal* and several special articles on medical education.

One hundred selected editorials written by Doctor Van Liere for *The West Virginia Medical Journal* were compiled in a small booklet and published in 1963 by our State Medical Association and the West Virginia University Medical Center. The book had excellent reviews in several national publications. Doctor Van Liere also is the author of "A Doctor Enjoys Sherlock Holmes." The Publication Committee is honored to bring to the attention of our profession this important book.—G.F.E.

Charles L. Goodhand, M. D.

Word was received of the untimely death of Dr. Charles L. Goodhand of Parkersburg as this issue of The Journal was placed on the press.

Doctor Goodhand, a Past President of the West Virginia State Medical Association and an Associate Editor of The Journal, suffered a heart attack while attending a medical meeting in Ocean City, Maryland.

The members of the Publication Committee are deeply grieved by his death and wish to extend sincere sympathy to Mrs. Goodhand and the other members of the family in their bereavement.

GENERAL NEWS

Dr. Parks Installed as President Of State Medical Association

Dr. Seigle W. Parks of Charleston was installed as President of the West Virginia State Medical Association at the final session of the House of Delegates during the 98th Annual Meeting at The Greenbrier on Saturday afternoon, August 28.

Dr. Albert C. Esposito of Huntington, the retiring President, hands the gavel to Dr. Seigle W. Parks of Charleston, the incoming President, in a brief ceremony during the second session of the House of Delegates.

Doctor Parks succeeded Dr. Albert C. Esposito of Huntington, who automatically will serve during the coming year as Chairman of the Council of the State Medical Association.

Doctor Parks served four years as a member of the Council and was elected Vice President in 1963 and President Elect in 1964.

Dr. Richard E. Flood President Elect

Dr. Richard E. Flood of Weirton, who was elected Vice President in 1964, was named President Elect. He will be installed as President at the 99th Annual Meeting at The Greenbrier in August, 1966.

Dr. Richard V. Lynch, Jr. of Clarksburg, who served two terms as a member of the Council, was elected Vice President. He has served on several key committees in addition to his service on the Council.

Doctor MacDonald Succeeds Doctor Barber

Doctor Kenneth G. MacDonald of Charleston was elected Treasurer to succeed Dr. Daniel N. Barber of the same city, who had served in that capacity for the past eight years. Doctor Barber did not seek reelection.

During the final session of the House of Delegates, the executive secretary was directed by the unanimous vote of the members present to transmit a formal note of thanks to Doctor Barber for his dedicated services to the Association.

Two New Members of The Council

Two new members of the Council were elected as follows:

Dr. Robert L. Chamberlain of Buckhannon (Third District); and Dr. W. P. Bittinger of Oak Hill (Sixth District).

Doctor Chamberlain succeeded Dr. John E. Echols of Richwood, who had served two terms and was not eligible for reelection. Doctor Bittinger succeeded Dr. D. Alene Blake of Oak Hill, who left the state to enter a residency program.

Four Council Members Reelected

Four members of the Council were reelected to serve terms of two years. They had served but one

Neighboring State Presidents Attend Annual Meeting

The presidents of the Ohio State Medical Association and the Kentucky Medical Association were among the honor guests at the 98th Annual Meeting at The Greenbrier in August. The following physicians, both of whom were accompanied by their wives, attended the meeting:

Dr. Delmas M. Clardy of Hopkinsville, Kentucky, President of the Kentucky Medical Association, and Dr. Henry A. Crawford of Cleveland, President of the Ohio State Medical Association.

Also attending the meeting were Dr. George W. Petznick of Shaker Heights, Ohio, a past president of the Ohio State Medical Association, and Dr. John H. Budd of Cleveland, AMA delegate from Ohio.

term and were eligible for reelection. They are as follows:

Dr. Joseph L. Curry of Wheeling (First District); Dr. Maynard P. Pride of Morgantown (Second District); Dr. I. Ewen Taylor of Huntington (Fourth District); and Dr. Buford W. McNeer of Hinton (Fifth District).

Holdover members of the Council who will serve during 1965-66 are as follows:

Dr. G. Thomas Evans of Fairmont (First District); Dr. Charles L. Leonard of Elkins (Second District); Dr. Andrew J. Weaver of Clarksburg (Third District); Dr. Richard W. Corbitt of Parkersburg (Fourth District); Dr. A. J. Villani of Welch (Fifth District); and Dr. William B. Rossman of Charleston (Sixth District).

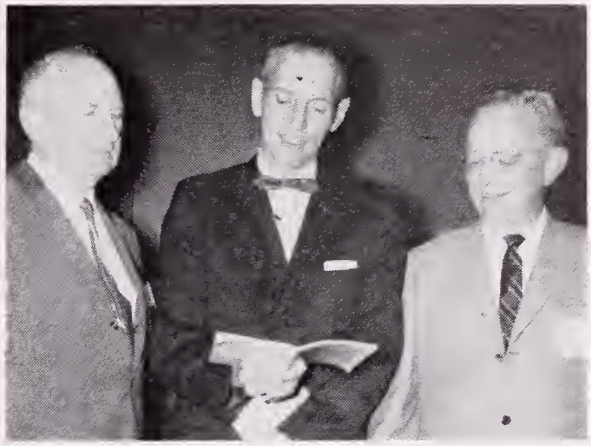
Doctor Holroyd Reelected AMA Delegate

Dr. Frank J. Holroyd of Princeton was reelected AMA delegate from West Virginia and Dr. Thomas G. Reed of Charleston was reelected AMA alternate. Each will serve a two-year term beginning January 1, 1966. Dr. C. A. Hoffman of Huntington is the holdover AMA delegate and Dr. D. E. Greeneltch of Wheeling, the holdover alternate.

New President Native of Tyler County

Doctor Parks, the new President, is a native of Middlebourne, Tyler County. He was graduated in 1935 from West Virginia University and attended the two-year West Virginia University School of Medicine. He received his M. D. degree in 1939 from the University of Maryland School of Medicine.

He served his internship at St. Agnes Hospital in Baltimore, 1939-40, and served a residency at the same hospital, 1940-41. He also served as assistant resident of medicine at the University of Maryland Hospital, 1947-48.



Three new officers of the Association glance at the program during a lull in the activities of the Annual Meeting. Left to right: Drs. W. P. Bittinger of Oak Hill and R. L. Chamberlain of Buckhannon, Councilors from the Sixth and Third Districts, respectively; and Dr. Kenneth G. MacDonald of Charleston, Treasurer.

Doctor Parks was engaged in general practice and industrial medicine in Fairmont from 1940 until January 1965 when he accepted appointment as Medical Director of the Chesapeake and Potomac Telephone Company of West Virginia, with offices in Charleston.

During World War II, Doctor Parks served in the Medical Corps of the United States Army and served as Executive Officer of the 432nd Medical Battalion from 1942-44 when he was named Commanding Officer of the 55th Medical Battalion in Bamberg, Germany. He was released in 1946 with the rank of Major.

The State Medical Association's new officers gathered behind the lectern for this picture following the second session of the House of Delegates. Left to right: Drs. Richard V. Lynch, Jr., of Clarksburg, Vice President; Kenneth G. MacDonald of Charleston, Treasurer; Seigle W. Parks of Charleston, President; Albert C. Esposito of Huntington, retiring President and new Chairman of the Council; and Richard E. Flood of Weirton, President Elect.

Dr. Edward R. Annis of Miami, Florida, addressed an AMPAC-WESPAC meeting Thursday night. Several hundred people gathered in Chesapeake Hall to hear Doctor Annis, a Past President of the AMA. Shown with Doctor Annis are Dr. Albert C. Esposito of Huntington (center), immediate Past President of the State Medical Association; Dr. Frank J. Holroyd of Princeton and Mrs. Charles L. Goodhand of Parkersburg (left), Co-Chairmen of WESPAC; and Mrs. Pat A. Tuckwiller of Charleston, Secretary-Treasurer of the organization.

Doctor Parks served as President of the Marion County Medical Society in 1947 and served a term as President of the West Virginia Chapter of the American Academy of General Practice. He served for eight years as Editor of "Mister Doc," official publication of the West Virginia Chapter of the AAGP, and currently is serving as one of the two West Virginia delegates to the AAGP.

He was honored by the AAGP in 1965 by being named chairman of the Committee on Scientific Assembly and he is in charge of the committee planning the scientific program for the 1966 meeting in Boston.

Doctor Parks served two terms as a member of the Council of the State Medical Association and was named Vice President in 1963 and President Elect in 1964.

While practicing in Fairmont, Doctor Parks served as plant physician for the Westinghouse Electric Company in that city and Medical Director of Monongahela Power Company. He is a fellow of the Industrial Medical Association and served for two years as a member of the Board of Directors of the Pittsburgh-Cleveland Society of the IMA. For the past three years he has been IMA Councilor for the State of West Virginia.

Doctor Parks is married to the former Eleanor Hastings, who is a past President of the Woman's Auxiliary to the State Medical Association. They have three children: Eleanor Louise, a graduate of Denison and Stanford Universities and who is now teaching school in California; Charles Langfitt, a senior at Ohio Wesleyan University; and Margaret Ann, a senior in high school.

The President Elect

Dr. Richard E. Flood, the President Elect, is a native of Glendale, Pennsylvania. He was graduated in 1937 from the University of Notre Dame and received his M. D. degree in 1941 from Jefferson Medical College in Philadelphia.

He served an internship at Harper Hospital in Detroit, 1941-42. During World War II he served for four years with the Medical Corps of the U. S. Army and was released in 1946 with the rank of Major.

He served terms as Secretary and President of the Hancock County Medical Society and was elected a member of the Council of the State Medical Association in 1959. He was named Vice President in 1964.

Resolutions Committee Meeting

The Committee on Resolutions held an open hearing on four resolutions lodged with the executive secretary at least two weeks prior to the first day of the meeting. The meeting was held Thursday afternoon, August 26, and was attended by several interested physicians in addition to members of the committee.

Shown in the picture on the left are participants in a Clinical Pathological Conference, which was one of the features of the scientific program. Left to right: Dr. Grover B. Swoyer of Charleston, who presented the pathologic findings; Dr. Leon Schiff of Cincinnati, clinical discussant; and Dr. Kenneth G. MacDonald of Charleston, moderator. Dr. J. Dennis Kugel of Charleston, who gave the radiographic findings, was absent when the picture was taken. Shown in the picture on the right are several of the officers and guests at the speakers table during the first general session. Left to right: Charles Hubbard of the AMA Department of Medicine and Religion; Dr. Walter H. Judd of Washington; Dr. Albert C. Esposito of Huntington; and Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee.

The report of the committee, which appears elsewhere in this issue of *The Journal*, includes the resolutions adopted by the House of Delegates at the second session on Saturday afternoon, August 28.

Amendments to the Constitution and By-Laws

The House of Delegates approved a large number of amendments to the Constitution and By-Laws which had been proposed by the Constitution and By-Laws Committee following a thorough study during the past year. The last major revision of the Constitution and By-Laws occurred in 1959. The amendments which were adopted appear elsewhere in this issue of *The Journal*.

Dr. James S. Klumpp of Huntington served as Chairman of the Committee and the other members were Drs. J. Russell Cook and Thomas J. Holbrook of Huntington; Nime K. Joseph of Wheeling; and Kenneth G. MacDonald of Charleston.

Addresses by Honor Guests

Several of the medical profession's foremost spokesmen appeared as guest speakers at the meeting.

Dr. James Z. Appel of Lancaster, Pennsylvania, President of the American Medical Association, was an honor guest and delivered an address before the first session of the House of Delegates on Wednesday afternoon.

Dr. Walter H. Judd, former medical missionary and member of Congress, was the speaker at the first general session on Thursday morning.

Dr. Edward R. Annis, a Past President of the American Medical Association, was the speaker at a meeting of the WESPAC organization on Thursday night.

Address by Dr. Albert C. Esposito

Dr. Albert C. Esposito of Huntington, the retiring President, presented his Presidential Address at the second session of the House of Delegates on Saturday afternoon. The complete text of Doctor Esposito's address appears elsewhere in *The Journal*, beginning on page 273.

Dr. Martha J. Coyner of Harrisville (second from left), a member of the Medical Scholarships Committee, is shown with the two 1965 scholarship recipients. They are Creel S. Cornwell, Jr., of Lost Creek (left) and William L. Mossburg of Morgantown, and Mrs. Mossburg.

Three of the principal speakers for the Annual Meeting are shown with Dr. Albert C. Esposito of Huntington, the retiring President. Left to right: Dr. James Z. Appel, President of the AMA; Dr. Edward R. Annis, a Past President of the AMA; and Dr. Walter H. Judd of Washington, former medical missionary and Congressman from Minnesota.

Scholarship Winners Introduced

William L. Mossburg of Morgantown and Creel S. Cornwell of Lost Creek were introduced at the second session of the House of Delegates by Dr. Martha Jane Coyner, a member of the Committee on Medical Scholarships, as the recipients of the 1965 Medical Scholarships Awards.

Mossburg and Cornwell are the eleventh and twelfth students to receive medical scholarship under the program which was inaugurated in 1958. In years prior to 1962, only a single scholarship was awarded.

1966 Meeting at The Greenbrier

The House of Delegates, prior to adjourning on Saturday afternoon, voted unanimously to return to The Greenbrier for the 99th Annual Meeting in 1966. The Council fixed August 25-27 as the dates for the coming year.

The total attendance for the meeting was 709, which compares with 627 in 1964. The physician registration was 442 compared to 389 last year. The Auxiliary registration was 182 compared to 138 in 1964, and the total registration for exhibitors and other guests was 85.

Chest Physicians Announce 1966 Essay Contest

The American College of Chest Physicians is offering three cash awards for the best essays prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases.

First prize will be $500. There also will be a second prize of $300 and a third prize of $200. Winners will be announced at the 32nd Annual Meeting of the American College of Chest Physicians, to be held in Chicago, June 23-27, 1966.

Application forms and additional information may be obtained by writing to Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois 60611.

Pre-Convention Council Meeting At The Greenbrier on Aug. 25

The pre-convention meeting of The Council was held at The Greenbrier in White Sulphur Springs on Wednesday morning, August 25, 1965, with the Chairman, Dr. Charles L. Goodhand of Parkersburg, presiding.

It was reported that four resolutions had been submitted for consideration by the House of Delegates. One of the resolutions, offered by the Kanawha Medical Society, called for the establishment of a third-party review committee as a standing committee of the Association.

Following discussion, the Council recommended to the Resolutions Committee that the resolution offered by the Kanawha Medical Society be amended in a manner which would make the third-party review committee a sub-committee of the Medical Economics Committee.

The final version of the resolution as adopted by the House of Delegates, together with the three other resolutions, are contained in the report of the Resolutions Committee which appears elsewhere in this issue of *The Journal.*

Amendments to the Constitution and By-Laws

Dr. James S. Klumpp of Huntington, Chairman of the Committee on Constitution and By-Laws, reported that the Committee had undertaken the task of revising the Constitution and By-Laws during the past twelve months. He said that the last major changes were made in 1959.

Following discussion, the Council approved the recommendations of the Committee and the Chairman was requested to report this action to the House of Delegates (The amendments adopted by the House of Delegates appear elsewhere in this issue of *The Journal*).

Medical Education and Hospitals

Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals, presented a detailed report on the activities of the Committee during the past year.

He said that the Committee had undertaken a study of postgraduate medical education programs in West Virginia, the curriculum at the West Virginia University School of Medicine, and the shortage of interns and residents on hospital staffs. An annual report of the committee was published in the August issue of *The Journal* and a supplementary report appears elsewhere in this issue.

Medical Examiners System

Dr. Richard W. Corbitt of Parkersburg, a member of the Council and Chairman of the Commission on Postmortem Examinations, reported that the Medical Examiners System still had not been placed into operation due to a lack of funds.

He said the Commission was established by an act of the Legislature in 1963, but that an appropriation for the Commission had not been included in the budget since that time.

Doctor Corbitt said that every effort would be made during the coming months to obtain an appropriation for the next fiscal year and he requested assistance in enlisting support of the members of the Legislature throughout the State.

Increase in Dues

Dr. D. E. Greeneltch of Wheeling, Chairman of the Budget and Personnel Committee, reported that the Committee had devoted much time during the past

The Publication Committee met during the Annual Meeting at The Greenbrier. Shown during a brief recess are (left to right): Dr. George F. Evans of Clarksburg, Editor of The Journal; and Drs. William L. Cooke of Charleston, D. E. Greeneltch of Wheeling, Charles L. Goodhand of Parkersburg, E. Lyle Gage of Bluefield, and Halvard Wanger of Shepherdstown. Dr. Edward J. Van Liere of Morgantown was out of the state and unable to attend the Annual Meeting.

two years to a study of the financial problems of the Association. He said that after much study it was the recommendation of the Committee that the annual dues should be increased from $50 to $80 annually.

The report of the Committee was approved unanimously and the Chairman was directed to report to the House of Delegates that the Council was in favor of a dues increase of $30.

Retiring Councilors

Doctor Esposito reported that Dr. John E. Echols of Richwood had completed four years of service as a member of the Council and therefore was not eligible for reelection.

The Council went on record as commending Dr. Charles L. Goodhand for his dedicated service as Chairman during the past year.

The following members of the Council were present at the meeting: Dr. Charles L. Goodhand of Parkersburg, Chairman; Dr. Albert C. Esposito of Huntington, President; Dr. Seigle W. Parks of Charleston, President Elect; Dr. Richard E. Flood of Weirton, Vice President; Dr. L. J. Pace of Princeton, Councilor-at-Large; and Drs. G. Thomas Evans, Fairmont; Charles L. Leonard, Elkins; Maynard P. Pride, Morgantown; Andrew J. Weaver, Clarksburg; John E. Echols, Richwood; I. Ewen Taylor, Huntington; A. J. Villani, Welch; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; and William B. Rossman, Charleston; and Mr. William H. Lively, Secretary ex officio.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. C. A. Hoffman of Huntington, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. D. E. Greneltch of Wheeling, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor, *The West Virginia Medical Journal*, Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. Pat A. Tuckwiller of Charleston, Chairman of the Committee on Medical Education and Hospitals; Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Joint Conference Committee; and Mr. David B. Weihaupt of Chicago, AMA Field Representative.

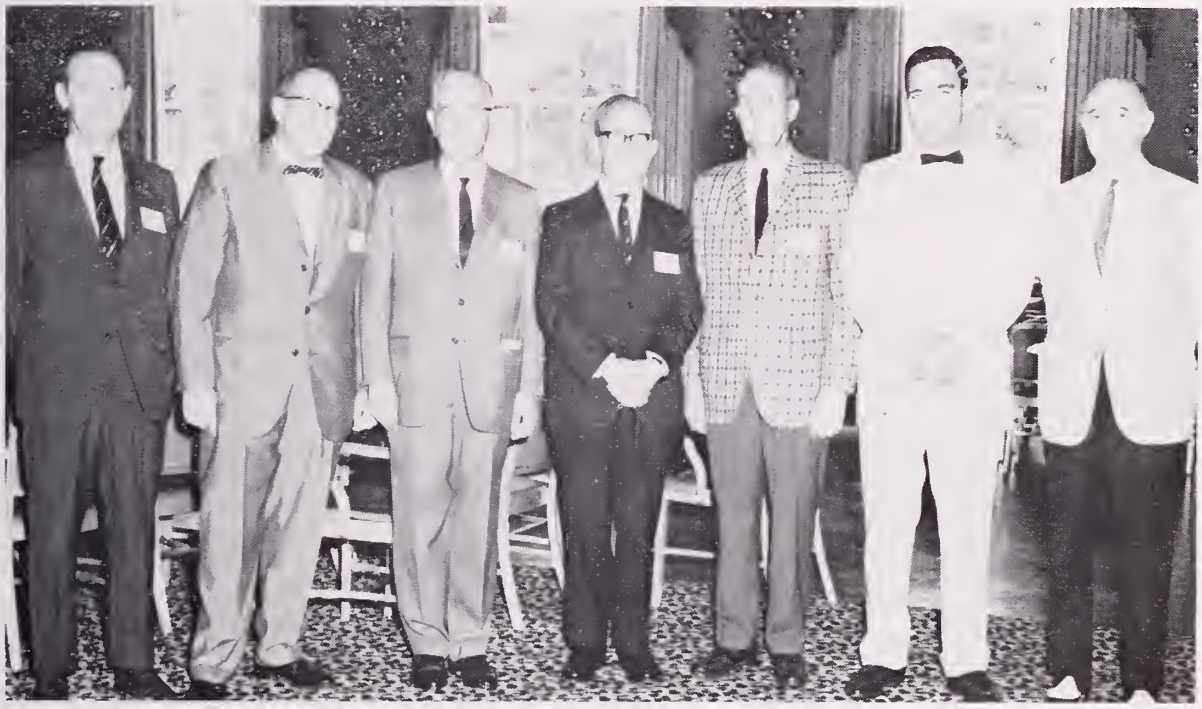
Also attending the meeting was Dr. James Z. Appel of Lancaster, Pennsylvania, President of the American Medical Association.

Fall Conference of Auxiliary In Huntington, Oct. 26-27

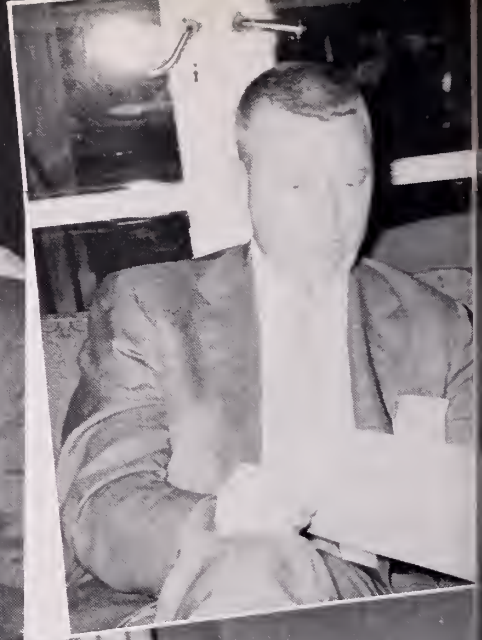
The annual Fall Conference and Director's Board Meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held at the Hotel Frederick in Huntington, October 26-27.

All state officers, county presidents and presidents elect are urged to attend. The chairmen of various committees will present reports during the two-day meeting.

Full details on the program and special activities will be sent to county presidents and state officers after Mrs. Wilson P. Smith of Huntington, President of the State Auxiliary, returns from the AMA Auxiliary Fall Board Conference, which will be held in Chicago, October 10-11.



Guest speakers were honored at a luncheon Friday in the bay of Chesapeake Hall. Left to right: Drs. Samuel D. McPherson, Jr., of Durham, North Carolina; Benjamin W. Drompp of Little Rock, Arkansas; Leon Schiff of Cincinnati; R. Gordon Douglas of New York City; Thomas E. Shaffer, of Columbus, Ohio; and William G. Thurman of Charlottesville, Virginia. At the extreme right is Dr. Richard J. Stevens of Huntington, Chairman of the Program Committee.



CAMERA HIGHLIGHTS

98th Annual Meeting

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

Aug. 26-28, 1965

(Identifying Notes on Page 300)

David B. Weihaupt Assigned as New AMA Field Representative

David B. Weihaupt of Chicago recently joined the staff of the Field Service Division of the American Medical Association and has been assigned to West Virginia and several other states. He succeeds Harry Hinton, who served in this capacity for the past two years. Mr. Hinton has accepted a position with AMPAC in Washington, D. C.

David B. Weihaupt

Mr. Weihaupt is a native of La Crosse, Wisconsin, and was graduated in 1955 from the University of Wisconsin.

He has been employed for the past six years by the Reflective Products Governmental Division of the Minnesota Mining and Manufacturing Company in Chicago.

He is married and the father of three daughters.

13 Student Nurses Receive Scholarship Awards

Thirteen nursing scholarships were awarded in September by the West Virginia Professional Nursing Education Trust, which is sponsored by the West Virginia Nurses Association.

Announcement of the awards was made by Mr. H. P. Porter of Charleston, Chairman of the Trust Fund, and Mrs. Josephine Fultz, President of the Nurses Association. New grants were awarded to four student nurses and grants were renewed for nine other students currently enrolled in state accredited schools of nursing.

Dr. Hampton St. Clair of Bluefield is a member of the Trust Fund and the secretary is Miss Juliann Ritter, R. N., Executive Director of the West Virginia Nurses Association.

Medical Seminar Cruise

Reservations are now being accepted by the Albany Medical College for the Seventh Medical Seminar Cruise, which will be conducted January 28 to February 7.

During the 10-day cruise, the faculty of the college will present a shipboard postgraduate program covering subjects in internal medicine, pediatrics, hematology, pathology and surgery. Members of the American Academy of General Practice may obtain 20 hours of credit by attending.

The cruise ship "S. S. Brasil" will visit the ports of Barbados, St. Thomas and San Juan.

Further information may be obtained by writing to the Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

Cerebral Palsy Symposium

The Mound Park Hospital Foundation, Inc., of St. Petersburg, Florida, is planning a symposium on "Cerebral Palsy: Modern Concepts—Allied Disorders, Rehabilitation" for November 11-13.

The registration fee is $5.00 and the course is approved for 18 accredited hours by the American Academy of General Practice.

Additional information may be obtained by writing to the Foundation at 701 Sixth Street South, St. Petersburg 33701.

HOPE Christmas Cards

Project HOPE headquarters will begin shipping HOPE's 1965 Christmas cards on October 1.

HOPE expects to sell more than 200,000 cards this year. Proceeds will go to The People-to-People Health Foundation, Inc., the parent organization of Project HOPE, which operates the hospital ship S. S. HOPE.

Cards are sold for $3 per box of 20 or $2.50 on orders of 10 boxes or more. They may be obtained from Project HOPE's national headquarters at 2233 Wisconsin Avenue, N. W., Washington, D. C. until November 30.

Camera Highlights

(See Pages 298-299)

(1) Dr. Athey R. Lutz of Parkersburg, a Past President of the Association, chats with Dr. Richard W. Corbitt of Parkersburg before the first session of the House of Delegates.

(2) Dr. George R. Callender, Jr., of Charleston (left), Chairman of the Medical Economics Committee, reviews a committee report with Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Joint Conference Committee.

(3) Dr. Albert C. Esposito of Huntington (left), retiring President of the State Medical Association, with Drs. Edward R. Annis and Walter H. Judd, two of the principal guest speakers.

(4) The camera catches Drs. C. A. Hoffman of Huntington and Frank J. Holroyd of Princeton, the Association's delegates to AMA.

(5) Dr. Seigle W. Parks of Charleston, President of the State Medical Association, and family: son Charles Langfitt; and (left to right) daughter Eleanor Louise, wife Eleanor Hastings and daughter Margaret Ann.

(6) Dr. James S. Klumpp of Huntington (right) a Past President of the State Medical Association and Chairman of the Committee on Constitution and By-Laws, talks with Dr. William F. Beckner, also of Huntington.

(7) New officers of the West Virginia State Society of Allergy and guest speakers are (left to right): Dr. Merle S. Scherr of Charleston, Secretary-Treasurer; Dr. Claude A. Frazier of Asheville, North Carolina; Dr. Nathan Schaffer of East Orange, New Jersey; Dr. Robert S. Mutch of Fairmont, Vice President; and Dr. Marshall J. Carper of Charleston, President.

(8) Dr. Jack Leckie of Huntington, a member of the Program Committee and President of the West Virginia Chapter, American Academy of General Practice; and Mrs. Leckie.

(9) Part of the receiving line at a reception honoring new officers of the State Medical Association.

Sections and Affiliated Societies Elect Officers for 1965-66

Meetings of sections and affiliated societies and associations of the West Virginia State Medical Association were held during the 98th Annual Meeting at The Greenbrier, August 26-28.

Officers for the coming year are:

Sections

Orthopedic Surgery: Carl J. Roncaglione, Charleston, President; Thomas F. Scott, Huntington, Vice President; and Arthur A. Abplanalp, Charleston, Secretary-Treasurer.

W. Va. Radiological Society: E. Walter Rice, Martinsburg, President; W. Alva Deardorff, Charleston, Vice President; and Karl J. Myers, Philippi, Secretary-Treasurer.

W. Va. Association of Pathologists: J. Evan Sadler, Huntington, Acting President.

W. Va. Academy of Oph. and Otol: Ralph W. Ryan, Morgantown, President; Worthy W. McKinney, Beckley, President Elect; and James Elliott Blaydes, Jr., Bluefield, Secretary-Treasurer.

Neurology, Neurosurgery and Psychiatry: W. E. Wilkinson, Beckley, President; David M. Wayne, Bluefield, President Elect; and Mildred Mitchell-Batemen, Charleston, Secretary.

Surgery: Harry F. Cooper, Beckley, President.

Internal Medicine: Arnold J. Brody, White Sulphur Springs, President; and E. L. Crumpacker, White Sulphur Springs, Secretary-Treasurer.

Urology: D. Franklin Milam, Morgantown, President; Harold Kagan, Huntington, Vice President; and Michel A. Glucksman, Elkins, Secretary-Treasurer.

W. Va. Pediatric Society: Russell V. Lucas, Jr., Morgantown, President; Emma Jane Freeman, Charleston, Vice President; and Meryleen B. Smith, Peterstown, Secretary-Treasurer.

Societies

W. Va. State Society of Allergy: Marshall J. Carper, Charleston, President; Robert S. Mutch, Fairmont, Vice President; and Merle S. Scherr, Charleston, Secretary-Treasurer.

W. Va. Society of Anesthesiologists: Jerill D. Cavender, Charleston, President; David A. Haught, Huntington, Vice President; and N. W. B. Craythorne, Morgantown, Secretary-Treasurer.

W. Va. Ob. and Gyn. Society: Dwight P. Cruikshank, Parkersburg, President; Daniel A. Mairs, Charleston, Vice President; and A. J. Villani, Welch, Secretary-Treasurer.

Physician Wins Chess Tournament

Dr. Siegfried Werthammer of Huntington won the West Virginia Chess Championship for the 13th time in Charleston in September. Doctor Werthammer posted an almost perfect score of 5½ to ½.

1966 Meeting at The Greenbrier

At the final session of the House of Delegates on Saturday, August 28, it was ordered by the unanimous vote of those members present that the 99th Annual Meeting of the State Medical Association be held at The Greenbrier in 1966. The meeting is scheduled for August 25-27.

Dr. Robert R. Brown of Romney Wins Medical Golf Tournament

Dr. Robert R. Brown of Romney won the medical golf tournament held in connection with the 98th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 26-28.

Doctor Brown shot a 69 to win his second title and a second leg on the beautiful trophy offered by the Hospital and Physicians Supply Company of Charleston. A physician can retire the trophy with three tournament victories.

The runner up was Dr. Joseph T. Mallamo of Fairmont who shot a 73. Both Drs. Brown and Mallamo now have two legs on the trophy.

Other low gross scorers were Drs. Jack C. Morgan of Fairmont, 78; Russell V. Lucas, Jr., of Morgantown, 79; Jack Leckie of Huntington, George H. Pierson, Jr., of Clendenin, and Robert A. Crawford, Jr., of Charleston, 82.

Dr. William C. Morgan, Jr., of Charleston, took low net honors. Other winners in this category were Drs. C. Stafford Clay of Huntington, Robert A. Crawford of Charleston, Charles M. Scott of Bluefield, Kenneth E. Owen of Marietta, Ohio, and John B. Markey of Charleston.

Dr. John J. Mahood won the blind bogey tournament and Dr. William C. Morgan of Charleston had the fewest number of putts with 25.

Prizes were awarded at a reception honoring officers of the State Medical Association on Saturday evening, August 28.

Dr. Joseph A. Smith of Dunbar served as Chairman of the Golf Committee.

Program Committee for 1966

Dr. Seigle W. Parks, President of the State Medical Association, has named Dr. Carl B. Hall of Charleston as Chairman of the Committee that will arrange the program for the 99th Annual Meeting at The Greenbrier in White Sulphur Springs, August 25-27, 1966.

The other members of the Committee are Drs. William E. Gilmore of Parkersburg, W. Gene Klingberg of Morgantown and Halvard Wanger of Shepherdstown.

State's 'Project Head Start' May Become Permanent

West Virginia's "Project Head Start", initiated during the past summer to assist communities in summer development centers for pre-school children of limited opportunity, may become a permanent part of the educational system with the aid of funds from the Office of Economic Opportunity.

State Health Director N. H. Dyer, in a recent issue of the "State of the State's Health", related how the State Department of Health, through its Division of Maternal and Child Health, had provided medical and nursing consultation, materials and participation to aid in the health appraisal aspects of "Head Start." He said that this was done in cooperation with local health departments, county boards of education, county and municipal governing agencies, local physicians and other voluntary and civic agencies.

Supplies needed by the county health departments for maintaining school health records and dental screening records; performing urine screening tests and tine tests; collection of throat culture specimens; and vaccines were also made available by the State Health Department.

Doctor Dyer pointed out that some 2,000 children from counties with limited local facilities and services were examined at mobile medical examination units from the Division of Maternal and Child Health during the project. These children received complete physical examinations, urinalysis, and immunization surveys. Components built into the project provide for referral services to several agencies or private physicians for necessary followup care.

According to Doctor Dyer, the more significant defects uncovered in the Head Start survey concerned heart defects, mental retardation, eye defects, orthopedic defects and ear problems.

Doctor Dyer said that "Improvement of a child's health cannot be overlooked in any program as comprehensive as 'Project Head Start' for improvement of health will undoubtedly aid in the expansion of mental, social and emotional development."

In another issue of the "State of the State's Health," Doctor Dyer discussed a survey conducted by the State Health Department involving the state's major health problem—heart disease. The survey, involving nursing home patients with cardiovascular disease, included 25 per cent of the state's licensed nursing homes.

He said the survey shows a need for improved communications between nursing homes and physicians and other health agencies to improve patient care. Educational programs in rehabilitation nursing techniques need to be developed to help nurses and aids in nursing homes. A plan to strengthen nursing consultation between nursing home personnel and public health nurses is also needed.

Doctor Dyer said "There is an additional need for basic facts concerning nursing homes in order to develop, test and sharpen equipment and methods of study." He urged communities to take stock of the role of their nursing homes and care facilities and concluded by saying that through intelligent community planning, with assistance from the state, nursing home patients can be restored to the highest possible level of health.

PG Course in Rheumatic Diseases

The American College of Physicians will conduct a postgraduate course on "Rheumatic Diseases: Pathology, Diagnosis and Treatment," in Boston, October 18-22.

Tuition fees are $60 for members of the ACP and $100 for non-members. Additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

Shown in the left picture are seven WVU School of Medicine faculty members who presented a program on "Emergency Maintenance of Life." Seated are Drs. Herbert E. Warden, Paul E. Huffington, Jr., and N. W. B. Craythorne. Back row: Drs. Clark K. Sleeth, Allen E. Yeakel, A. C. Edmundowicz and Bernard Zimmermann. Right panel shows Dr. G. Thomas Evans of Fairmont (left) and Mr. David B. Weihaupt, AMA Field Representative, in the Exhibit Center.

Potomac Chapter, ACCP, Meeting In Charleston on Oct. 31

Thirteen physicians will present papers at the 21st annual meeting of the Potomac Chapter of the American College of Chest Physicians which will be held at the Holiday Inn in Charleston on Sunday, October 31.

Dr. Morris H. O'Dell of Charleston, President of the Chapter, announced that registration for the one-day meeting will begin at 8:30 A.M. The scientific session will begin at nine o'clock and end at four, at which time there will be a business meeting.

Doctor O'Dell will preside at the morning session and the presiding officer for the afternoon session will be Dr. Willard Pushkin of Charleston.

Morning Session

The speakers and their subjects at the scientific sessions will be as follows:

"The Relationship of Air Pollution, Emphysema and Heart Disease."—I. E. Buff, M. D., Cardiology and Internal Medicine, Charleston.

"Newer Concepts in the Treatment of Pneumoconiosis."—Werner A. Laqueur, M. D., Chief, Division of Pathology, Appalachian Regional Hospital, Beckley.

"Exercise in Coronary Disease."—Harold Selinger, M. D., Cardiology and Internal Medicine, Charleston; and Willard Pushkin, Chief of Medicine, Charleston General Hospital.

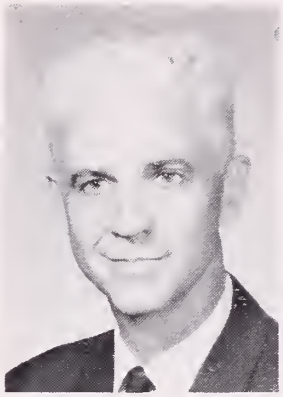
"Extensive Resections in Carcinoma of the Lung." —Richard Currie, M. D., Assistant Professor of Surgery, WVU School of Medicine, Morgantown.

"Clinical Syndromes with Mycoplasma Pneumoniae Infection."—Charles E. Andrews, M. D., Professor of Medicine, WVU School of Medicine, Morgantown.

"Current Status of the Rheumatic Fever Control Program in West Virginia."—N. Allen Dyer, M. D., Director, Bureau of Heart Disease Control, State Department of Health, Charleston.

Afternoon Session

"Bacterial Endocarditis."—David Z. Morgan, M. D., Assistant Professor of Medicine, WVU School of Medicine, Morgantown.



Morris H. O'Dell, M. D.

Richard Currie, M. D.

"Heart Block."—William Jacobs, M. D., Department of Medicine, WVU School of Medicine, Morgantown.

"Abdominal Aortic Aneurysms."—R. W. Neilson, Jr., M. D., Chief of Thoracic Surgery, Bluefield Sanitarium, Bluefield.

"Problems of Atelectasis in Childhood."—Thomas Tarnay, M. D., Assistant Professor of Surgery, WVU School of Medicine, Morgantown.

"Anomalous Muscle Bundle of Right Ventricle: Description and Diagnosis."—Russell V. Lucas, Jr., M. D., Associate Professor of Pediatrics; and (Surgical Treatment) Herbert E. Warden, M. D., Professor of Surgery, WVU School of Medicine, Morgantown.

Doctor O'Dell announced that a buffet luncheon will be served for the guest speakers and other participants at the meeting.

PG Course In Therapeutics

The American College of Physicians will conduct a postgraduate course in "Pathophysiological Basis of Therapeutics" at the University of Kentucky Medical Center in Lexington, November 15-19.

Fees are $60 for ACP members and $100 for nonmembers.

Registration forms and other information may be obtained from Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

In left panel, Dr. F. P. Rhoades of Detroit (center), an Exhibitor at the Annual Meeting, discusses his exhibit with Drs. Carl B. Hall of Charleston (left) and L. Dale Simmons of Clarksburg. Right panel shows the Nominating Committee, which met Friday afternoon. Left to right are Drs. Buford W. McNeer of Hinton; John E. Echols of Richwood; L. J. Pace of Princeton, the Chairman; Charles L. Leonard of Elkins; and Richard W. Corbitt of Parkersburg.

Tenth Annual Postgraduate Institute In Martinsburg, October 29-31

Thirty-two speakers, including 31 physicians and other scientists and news columnist Drew Pearson, are on the program for the 10th Annual Potomac-Shenandoah Valley PG Institute, which will be held in Martinsburg, October 29-31.

The three-day meeting is sponsored jointly by the Potomac-Shenandoah Valley PG Institute and the West Virginia Chapter of the American Academy of General Practice. Members of the AAGP will be allowed 18½ hours of credit for attendance at the meeting.

Dr. Morris Fishbein will be the speaker at the annual banquet Saturday evening at the Shenandoah Hotel. His topic will be "Medicine and the Changing Social Order."

Pearson, author of the newspaper column "Washington Merry-Go-Round", will speak at a dinner Friday evening.

Dr. Halvard Wanger of Shepherdstown, the Executive Director, said scientific and industrial exhibits will be located in the Shenandoah Hotel and the scientific sessions will be held in the Apollo Theater.

Friday Morning Session

The first scientific session will be held on Friday Morning, October 29. The first hour will be devoted to basic science, and the remainder of the session will be devoted to pediatrics. A panel discussion will follow the pediatrics program.

The speakers and their subjects will be:

"Molecular View of Cardiac Contraction—Practical Applications"—Michael F. Wilson, M. D., Professor and Chairman, Department of Physiology, West Virginia University School of Medicine.

"Calcium Homeostasis"—Alexander D. Kenny, Ph.D., Associate Professor of Pharmacology, West Virginia University.

"Modern Therapy of Meningitis"—McLemore Birdsong, M. D., Chairman and Professor, University of Virginia.

"Placental Barrier"—Doris Howell, M. D., Head and Professor, Department of Pediatrics, Women's Medical College of Pennsylvania.

"Antimicrobial Therapy in Infancy"—Hans Keitel, M. D., Head and Professor of Pediatrics, Jefferson Medical College.

"Lesions of the Trachea and Esophagus in Children"—Joseph M. Lopresti, M. D., Associate Clinical Professor at Georgetown and George Washington Universities.

Moderator of the panel discussion at the end of the morning session will be Dr. Barbara Jones, Associate Professor of Pediatrics at the WVU School of Medicine. A round table luncheon will follow.

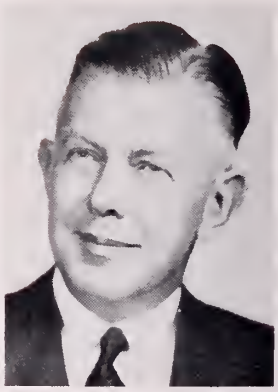
Afternoon Session

The afternoon session on Friday will be devoted to medicine. Speakers and their subjects are as follows:

"Coronary and Renal Arterial Occlusive Disease: Focal or Multicentric"—John H. Moyer, III, M. D., Chairman and Professor of Medicine, Hahnemann Medical College and Hospital.

"Physical Diagnosis of the Chest and Abdomen"—Louis Krause, M. D., Professor of Medicine, University of Maryland.

Drew Pearson



John C. Krantz, Jr., Ph.D.

"Silent Coronary Artery Disease and Myocardial Infarction"—Benjamin Manchester, M. D., Associate Professor, George Washington University.

"Ankylosing Spondylitis"—John W. Sigler, M. D., Associate Physician, Division of Rheumatology, Henry Ford Hospital, Detroit.

Dr. A. C. Edmundowicz, Assistant Professor of Medicine at the WVU School of Medicine, will serve as moderator of a panel discussion at the end of the Friday afternoon session.

Friday Night Dinner

After Mr. Pearson's address at the dinner Friday evening, there will be a showing of the film, "The One Who Heals", which was produced by the Department of Medicine and Religion of the American Medical Association.

Saturday Morning Program

The Saturday morning program will be devoted to basic science and medicine. The program is as follows:

"Applied Anatomy Relating to Tumors Within the Neural Canal"—Robert J. Johnson, M. D., Chairman and Professor, Department of Anatomy, University of Pennsylvania Graduate School.

"Fetal and Newborn Physiology"—Doris A. Howell, M. D., Head and Professor, Department of Pediatrics, Women's Medical College of Pennsylvania.

"The Mechanism of the Action of Drugs on the Circulation"—John C. Krantz, Jr., Ph.D., Head and Professor of Pharmacology, University of Maryland.

"Differential Diagnosis of the Painful Arm and Hand"—Charles Van Buskirk, M. D., Clinical Professor of Neurology, University of Maryland.

"The Significance of Abnormal Ammonia Metabolism"—Samuel Bessman, M. D., Professor of Research, University of Maryland.

"The Annual Physical"—Perry S. MacNeal, M. D., Associate Professor of Clinical Medicine, University of Pennsylvania.

A panel discussion, moderated by Dr. Robert Marshall, Professor of Medicine at the WVU School of Medicine, will be followed by another round table luncheon.

Afternoon Session

The following program will be presentated Saturday afternoon:

"The Pathology of Bronchial Asthma, Before and After Prolonged Steroid Therapy"—Leslie N.

Perry S. MacNeal, M. D.

Morris Fishbein, M. D.

Gay, M. D., Associate Professor of Medicine, Johns Hopkins University.

"Peptic Ulcer"—Pharmacology of the G.I. Tract"—John C. Krantz, Jr., Ph.D., Head and Professor of Pharmacology, University of Maryland.

"Difficulties in the Evaluation of Gallbladder Disease"—Charles M. Thompson, M. D., Head and Professor of Gastroenterology, Hahnemann Medical College.

"The Bicentennial of Medical Education in the United States"—Morris Fishbein, M. D.

Doctor Fishbein will moderate the panel discussion at the conclusion of the afternoon session.

Banquet Saturday Evening

A reception will be followed Saturday evening by the annual banquet, at which Doctor Fishbein will be the principal speaker. The annual dance, featuring music by the Russ Lang Orchestra from Washington, D. C., will begin at 9:30 p. m.

Sunday Morning Session

The Sunday morning program will be devoted to obstetrics and gynecology after one hour of basic science. The program is as follows:

"The Anatomical Explanation of Tumors of Chromaffin Tissue"—Robert J. Johnson, M. D., Chairman and Professor, Department of Anatomy, University of Pennsylvania Graduate School.

"Mechanisms of Action of the Newer Antihypertensives"—William W. Fleming, Ph.D., Associate Professor of Pharmacology, WVU Medical Center.

"Intrauterine Contraceptive Devices"—D. Frank Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland.

"Management of the Menopausal Patient"—Paul O. Klingensmith, M. D., Associate Professor of Obstetrics and Gynecology, University of Pennsylvania.

"Modern Trends in Obstetrics and Gynecology"—Humbert L. Riva, M. D., Chairman and Professor of Obstetrics and Gynecology, New Jersey Medical College (Seton Hall).

"The Use of X-ray in Obstetrics and Gynecology"—James G. Sites, M. D., Associate Professor, Department of Obstetrics and Gynecology, George Washington University.

Dr. Dean Goplerud, Instructor in Obstetrics and Gynecology at WVU, will moderate the panel discussion, which will follow the morning program.

Sunday Luncheon Program

Dr. Perry S. MacNeal, Associate Professor of Clinical Medicine at the University of Pennsylvania Medical School, will speak at a luncheon Sunday afternoon. Doctor MacNeal's topic will be "Disease of Medical Progress."

The final scientific session Sunday afternoon will be devoted to surgery. The program is as follows.

"Tumors of the Urinary Tract"—John D. Young, Jr., M. D., Head and Professor of Urology, Urological Surgery, University of Maryland.

"Diagnosis and Treatment of Hyperthyroid Disease"—Robert J. Coffey, M. D., Director of Department and Professor of Surgery, Georgetown University.

"Esophagitis"—Brian B. Blades, M. D., Department Head and Professor of Surgery, George Washington University.

The final panel discussion will be moderated by Dr. Richard Currie, Assistant Professor of Surgery, WVU School of Medicine.

The registration fee is $25 for the entire three-day course and $10 for a single day. Further information may be obtained by writing to Dr. Halvard Wanger, Executive Director, Box 175, Shepherdstown, West Virginia.

Standards for Nursing

The West Virginia Nurses Association is asking physicians to help implement "Standards for Organized Nursing Services."

In a letter to the West Virginia State Medical Association recently, the nurses association asked that physicians use the standards as guidelines to upgrade nursing services in health care facilities.

Copies of "Standards for Organized Nursing Services" may be ordered from the American Nurses Association, 10 Columbus Circle, New York, New York 10019. The price is 35 cents per copy.

Dr. Thomas C. Wilson, a Beckley pathologist, was guest speaker at the annual convention of the West Virginia Society of Medical Technologists in Logan on August 21.

Paul Gauze of Logan was elected President of the group. Other new officers are Hobert Crawford of New Martinsville, Vice President; Mrs. Hattie Donnelly of Logan, Secretary; and Lewis B. Smith of Charleston, Treasurer.

Members To Receive Revised Edition

A revised edition of the Constitution and By-Laws of the West Virginia State Medical Association will be mailed to all members prior to the end of the year.

The revised edition will include all amendments adopted at the annual meeting in August as well as amendments adopted since the Constitution and By-Laws was last revised in 1959.

Mrs. Wilson P. Smith Installed As Auxiliary President

Mrs. Wilson P. Smith of Huntington was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the Annual Meeting at the Greenbrier, August 26-28.

She succeeds Mrs. George A. Curry of Morgantown.

The 41st Auxiliary Convention, which was held in conjunction with the 98th Annual Meeting of the State Medical Association, attracted more than 180 wives of physicians.

Mrs. Wilson P. Smith

New officers, including Mrs. Smith, were installed Friday morning, August 27, by Mrs. Richard A. Sutter of St. Louis, Missouri, President of the Woman's Auxiliary to the American Medical Association. Mrs. Jordan Kelling of Waverly, Missouri, President of the Woman's Auxiliary to the Southern Medical Association, also was an honor guest of the State Auxiliary.

Mrs. Sutter delivered the keynote address on Thursday morning, August 26.

Keynote Address

"There is probably no area in which there is greater lack of understanding than in medical care," Mrs. Sutter said. "With built-in obsolescence an accepted practice in the business world, it is hard for the public to understand that medicine is the only business or profession save perhaps the clergy which is constantly seeking to eliminate the reasons for its existence."

She said the world is rapidly changing and added: "We are faced today with not *whether* government shall provide security but with *how* it will be provided, and *how much*."

Inaugural Address

In her inaugural address, Mrs. Smith reminded members that their responsibilities include assisting the State Medical Association in the advancement of public health; coordinating the activities of component auxiliaries; and cultivating friendly relations among physicians' families.

Concerning the first responsibility, she said:

"Have you done your share for the cancer, tuberculosis, heart and the numerous other drives? . . . What do you do for your church, your Woman's Club, your Garden Club and all the other civic organizations to which you belong? Are you congenial? Do you help? If you do, then you are assisting the medical profession to the fullest extent, for this is the finest kind of public relations. . .

"We as doctors' wives cast a shadow wherever we go. This shadow may be strong, bright and welcome wherever it may fall, or it can be weak, not clear and not always there."

Mrs. Smith also urged the physicians' wives to help improve the state's image.

Mrs. Kelling's Remarks

Mrs. Kelling outlined the purpose of the Southern Medical Auxiliary which she said has two projects in addition to fostering friendliness among the families of doctors. One project is the collection of a library of historical facts, biographies and little-known stories of medicine, especially in the South.

"I urge all states to send literary contributions to this library," she said, "for it may be valuable to many in the future to have this material collected under one roof."

The other Southern Medical Auxiliary project is the honoring of physicians on Doctors' Day, March 30.

The President's Report

In her report, Mrs. Curry listed a number of projects being undertaken by the state and county auxiliaries. She said innovations at the state level included the appointment of a Chairman of International Health Activities and that 16 of the 22 county auxiliaries are participating in a world health program.

Mrs. Curry said the Auxiliary membership of 1,029 is about 73 per cent of potential.

Auxiliary members joined their husbands in Governor's Hall for the Association's opening exercises en Thursday morning. The principal speaker at that session was Dr. Walter H. Judd.

New Officers

Mrs. Hu C. Myers of Philippi was named President Elect of the Auxiliary and will be installed as President at The Greenbrier next August.

Other new officers for the coming year are:

Mrs. J. A. B. Holt of Charleston, First Vice President; Mrs. Claude R. Davisson of Weston, Second Vice President; Mrs. Ray Kessel of Logan, Third Vice

President; Mrs. Rupert Powell of Fairmont, Fourth Vice President; Mrs. J. Dennis Kugel of Charleston, Treasurer; Mrs. J. N. Jarrett of Oak Hill, Recording Secretary; Mrs. M. L. White, Jr., of Huntington, Corresponding Secretary; and Mrs. D. E. Greeneltch of Wheeling, Parliamentarian.

Committees

The following appointments to committee chairmanships and other Auxiliary offices were announced:

Mrs. M. Bruce Martin of Huntington, AMA-ERF; Mrs. Joseph A. Smith of Dunbar, Archives and History; Mrs. William A. Thornhill, Jr., of Charleston, By-Laws and Handbook; Mrs. Richard Starr of Beckley, Community Service; Mrs. Frank Peck of Huntington, Convention Chairman, and Mrs. Ronald Crissey of Huntington, Co-Chairman.

Mrs. Homer D. Martin of Elkins, Disaster Preparedness and Safety; Mrs. Clarence H. Boso of Huntington, Editor of the State News Bulletin; Mrs. Joseph E. Chambers of Huntington, Circulation Manager of the News Bulletin; Mrs. Harry E. Beard of Huntington, Finance; Mrs. Charles H. Hiles of Wheeling, Health Careers; Mrs. L. Dale Simmons of Clarksburg, Legislation; and Mrs. Clark K. Sleeth of Morgantown, Liaison to Woman's Auxiliary to the Student American Medical Association.

Mrs. Hu Myers of Philippi, Membership; Mrs. Buford W. McNeer of Hinton, Members-at-Large; Mrs. John Hash of Charleston, Mental Health; Mrs. Albert C. Esposito of Huntington, International Health Activities; Mrs. Robert J. Tchou of Williamson, National Bulletin; Mrs. Myer Bogarad of Weirton, Necrology; Mrs. John E. Echols of Richwood, Press and Publicity; Mrs. John Mahood of Bluefield, Program; Mrs. Lynwood D. Zinn of Clarksburg, Rural Health and Nutrition; and Mrs. Ross P. Daniel of Beckley, Southern Medical Councilor.

Executive and Advisory Boards

Mrs. George A. Curry of Morgantown and Mrs. Pat A. Tuckwiller of Charleston, both Past Presidents of the Auxiliary, were named by Mrs. Smith to the Board of Directors.

Dr. Albert C. Esposito of Huntington, Immediate Past President of the State Medical Association, will serve as Chairman of the Medical Advisory Board to the Auxiliary. Doctor Esposito's board also will include Drs. Myer Bogarad of Weirton; J. C. Huffman of Buckhannon, a Past President of the State Medical Association; Joseph Farrell of Huntington; and Wilson P. Smith of Huntington.

Mrs. Smith Former TV Personality

A native of Huntington, Mrs. Smith is a graduate of Iowa State College. She served as a home economist for various firms and her last job was conducting a popular television program known as "Maida's Kitchen."

The Smiths have three sons and one daughter—Wilson Jr., who is in high school; Ed and Stephen, who are junior high school students; and Mina, who is enrolled in elementary school.

Mrs. Smith's father, the late E. Q. Swan, was a longtime principal of Huntington High School and Assistant Superintendent of Cabell County Schools.

The new Auxiliary President has been active in the PTA and has served as President of the Woman's Auxiliary to the Cabell County Medical Society.

Auxiliary Ball

A large crowd attended the 41st Anniversary Ball, sponsored by the Auxiliary, which was held in Chesapeake Hall on Friday evening.

Left picture shows officials of auxiliaries at the county, state, regional and national levels. Left to right: Mrs. Jordan Kelling of Waverly, Missouri, President of the Southern Medical Auxiliary; Mrs. George A. Curry of Morgantown, retiring President of the State Auxiliary; Mrs. Richard A. Sutter of St. Louis, President of the AMA Auxiliary; and Mrs. James H. Walker of Charleston, President of the Auxiliary to the Kanawha Medical Society. Other picture shows new officers of the State Auxiliary. Left to right: Mrs. C. R. Davisson of Weston and Mrs. Rupert W. Powell of Fairmont, Vice Presidents; Mrs. Joe N. Jarrett of Oak Hill, Recording Secretary; Mrs. J. A. B. Holt of Charleston, Vice President; Mrs. Wilson P. Smith of Huntington, President; Mrs. J. Dennis Kugel of Charleston, Treasurer; and Mrs. Hu C. Myers of Philippi, President Elect. Mrs. Ray Kessel of Logan, a Vice President, was not present for the picture.

Standing and Special Committees Named by Doctor Parks

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, has named the standing and special committees which will function during his one-year term.

The list of committees is as follows:

Aging

Myer Bogarad, Weirton, Chairman; Thomas H. Blake, St. Albans; E. Lyle Gage, Bluefield; Philip Johnson, Fairmont; and Thomas H. McGavack, Martinsburg.

Cancer

Hu C. Myers, Philippi, Chairman; F. Lloyd Blair, Parkersburg; David B. Gray, and Theodore P. Mantz, Charleston; W. Hampton St. Clair, Jr., Bluefield; Delbert C. Smith, Fairmont; Alvin L. Watne, Morgantown; Chauncey B. Wright, Huntington; and Bernard Zimmermann, Morgantown.

Constitution and By-Laws

James S. Klumpp, Huntington, Chairman; G. Thomas Evans, Fairmont; and Kenneth G. MacDonald, Charleston.

Insurance

C. A. Hoffman, Huntington, Chairman; W. P. Bittinger, Oak Hill; Robert L. Chamberlain, Buckhannon; R. U. Drinkard, Wheeling; Upshur Higginbotham, Bluefield; Athey R. Lutz, Parkersburg; Kenneth G. MacDonald, Charleston; Joe E. McCary, Princeton; Buford W. McNeer, Hinton; and Andrew J. Weaver, Clarksburg.

Inter-Professional Relations

J. C. Huffman, Buckhannon, Chairman; Andrew E. Amick, Lewisburg; Ray M. Bobbitt, Huntington; R. C. Cowan, Jr., Parkersburg; V. L. Dyer, Petersburg; William E. Gilmore, Parkersburg; E. F. Heiskell, Jr., Morgantown; Mary Jordan, Fairmont; Clyde Litton, Charleston; W. L. Neal, Huntington; Paul H. Revercomb, Charleston; W. Fred Richmond, Beckley; L. Dale Simmons, Clarksburg; Tracy N. Spencer, Jr., South Charleston; J. L. Thompson, Weirton; and E. J. Van Liere, Morgantown.

Legislative

Frank J. Holroyd, Princeton, Chairman; John T. Chambers, Charleston; Richard W. Corbitt, Parkersburg, George A. Curry, Morgantown; Joseph L. Curry, Wheeling; Richard E. Flood, Weirton; D. E. Greeneltch, Wheeling; N. B. Groves, Martinsburg; John W. Hash, Charleston; Logan W. Hovis, Parkersburg; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Jack Leckie, Huntington; Charles W. Merritt, Beckley; David W. Mullins, Logan; Thomas G. Reed, Charleston; Joseph D. Romino, Fairmont; William B. Rossman and Page H. Seekford, Charleston; I. Ewen Taylor, Huntington; David B. Thornburg, Parkersburg; A. J. Villani, Welch; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; and Ward Wylie, Mullens.

Maternal and Perinatal Fetal Welfare

Charles L. Goodhand, Parkersburg, Chairman; Jack Basman, Charleston; Clarence H. Boso, and Thomas J. Conaty, Huntington; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; Thomas G. Folsom, Huntington; Emma Jane Freeman, Charleston; N. W. Fugo, Morgantown; George L. Grubb, Charleston; C. S. Harrison, Clarksburg; William S. Herold, Charleston; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; Charles W. Merritt, Beckley; Meryleen B. Smith, Peterstown; A. J. Villani, Welch; and Gates J. Wayburn, Huntington.

Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; J. Marshall Carter, Huntington; R. L. Chamberlain, Buckhannon; George F. Fordham, Mullens; William E. Gilmore, Parkersburg; Henry R. Glass, Jr., Charleston; J. W. Hesen, Jr., Morgantown; Joe N. Jarrett, Oak Hill; Gregory B. Krivchenia, Wheeling; Jack C. Morgan, Fairmont; George Naymick, Weirton; W. H. Rardin, Beckley; Herbert N. Shanes, Grafton; and Harlan A. Stiles, Huntington;

Medical Economics

George R. Callender, Jr., Charleston, Chairman; Carter F. Cort, Fairmont; Joseph L. Curry, Wheeling; A. B. Curry Ellison, Charleston; Walter H. Gerwig, Clarksburg; D. E. Greeneltch, Wheeling; N. B. Groves, Martinsburg; Carl B. Hall and Henry M. Hills, Jr., Charleston; C. A. Hoffman and Thomas J. Holbrook, Huntington; Ray M. Kessel, Logan; Jack Leckie, Huntington; John D. Lindsay, Jr., Fairmont; Thomas P. Long, Man; Athey R. Lutz, Parkersburg; Richard V. Lynch, Jr., Clarksburg; Kenneth G. MacDonald, Charleston; Worthy W. McKinney, Beckley; J. C. Pickett, Morgantown; W. Fred Richmond, Beckley; Charles M. Scott, Bluefield; James T. Spencer, Charleston; Harry S. Weeks, Jr., Wheeling; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Arnold J. Brody, White Sulphur Springs; William A. Ehrgott, Fairmont; William E. Gilmore, and Charles L. Goodhand, Parkersburg; F. A. Hamilton, Jr., Martinsburg; Richard Hamilton, St. Marys; Upshur Higginbotham, Bluefield; David Z. Morgan, Morgantown; Thomas G. Reed, and Edwin M. Shepherd, Charleston; Clark K. Sleeth, Morgantown; A. C. Thompson, Elkins; William A. Thornhill, Jr., Charleston; Andrew J. Weaver, Clarksburg; and M. B. Williams, Wheeling.

Medical Scholarships

J. P. McMullen, Wellsburg, Chairman; Martha Jane Coyner, Harrisville; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; John Mark Moore, Wheeling; and Clark K. Sleeth, Morgantown.

Medical Emergencies and Civil Defense

John J. Mahood, Bluefield, Chairman; Harold D. Almond, Buckhannon; Charles H. Hiles, Wheeling; John A. B. Holt, Charleston; Joseph T. Mallamo, Fairmont; Homer D. Martin, Dailey; James G. Ralston, Clarks-

burg; William S. Sadler, Barboursville; and Harlan A. Stiles, Huntington.

Mental Health

William B. Rossman, Charleston, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Roy A. Edwards, Jr., Huntington; Charles L. Goodhand, Parkersburg; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; Boylston D. Smith, Jr., Clarksburg; A. L. Wanner, and Stephen D. Ward, Wheeling; William E. Wilkinson, Beckley; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; Francis L. Coffey, Huntington; Walter H. Gerwig, Jr., Clarksburg; Charles M. Scott, Bluefield; Jack J. Stark, Belpre, Ohio; and Ward Wylie, Mullens.

Program

Carl B. Hall, Charleston, Chairman; William E. Gilmore, Parkersburg; W. Gene Klingberg, Morgantown; and Halvard Wanger, Shepherdstown.

Public Service

Joseph L. Curry, Wheeling, Chairman; John M. Bobbitt, Huntington; William L. Cooke, Charleston; George A. Curry, Morgantown; C. R. Davisson, Weston; G. Thomas Evans, Fairmont; S. William Goff, Parkersburg; N. B. Groves, Martinsburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; Jack Leckie, Huntington; L. J. Pace, Princeton; Page H. Seekford, Charleston; Jack J. Stark, Belpre, Ohio; and Stephen D. Ward, Wheeling.

Resolutions

Maynard P. Pride, Morgantown, Chairman; Albert C. Esposito, Huntington; Charles L. Goodhand, Parkersburg; Thomas J. Holbrook, Huntington; J. C. Huffman, Buckhannon; Charles L. Leonard, Elkins; and Kenneth G. MacDonald, Charleston.

Rehabilitation

J. C. Pickett, Morgantown, Chairman; C. B. Buffington, Wheeling; Jean P. Cavender, and Kenneth L. Clark, Charleston; James A. Heckman, Huntington; Harold H. Kuhn, Charleston; Buford W. McNeer, Hinton; and Ralph H. Nestmann, and Edwin M. Shepherd, Charleston.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Harold D. Almond, Buckhannon; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; B. S. Brake, Clarksburg; Del Roy R. Davis, Kingwood; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; J. C. Huffman, Buckhannon; Charles T. Lively, Weston; Guy R. Post, Fairmont; Clark K. Sleeth, Morgantown; and Charles E. Staats, Charleston.

Syphilis

N. H. Dyer, Charleston, Chairman; Ross O. Bell, and Paul V. Graham, Wheeling; Paul L. McCuskey, Parkersburg; C. Y. Moser, Kingwood; A. L. Osterman, Wheeling; Frank M. Peck, Huntington; Thomas L. Thomas, Wheeling; and Lyle D. Vincent, Parkersburg.

Tuberculosis

William L. Cooke, Charleston, Chairman; Charles E. Andrews, Morgantown; Oliver H. Brundage, Parkersburg; J. Russell Cook, Huntington; N. Allen Dyer, Bluefield; George F. Evans, Clarksburg; Ralph H. Nestmann, Charleston; Rupert W. Powell, Fairmont; James H. Walker, Charleston; and M. L. White, Jr., Huntington.

SPECIAL COMMITTEES

AMA-ERF

J. Keith Pickens, Clarksburg, Chairman; Harry F. Cooper, Beckley; Richard W. Corbitt, Parkersburg; John E. Echols, Richwood; Robert J. Fleming, Morgantown; John W. Hash, Charleston; Joe N. Jarrett, Oak Hill; Jack Leckie, Huntington; Buford W. McNeer, Hinton; Jack C. Morgan, Fairmont; Earl S. Phillips, Wheeling; and Donald R. Roberts, Elkins.

School Health

Peter A. Haley, Charleston, Chairman; Grover C. Hedrick, Jr., Beckley; Robert G. Janes, Fairmont; Thomas L. Thomas, Wheeling; Thomas G. Folsom, Huntington; A. M. Jones, Parkersburg; George W. Rose, Clarksburg; and Lyle D. Vincent, Parkersburg.

WVU Liaison

Thomas L. Harris, Parkersburg, Chairman; Randall Connolly, Vienna; George F. Evans, Clarksburg; Charles L. Goodhand, Parkersburg; John W. Hash, and John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Claude S. Lawson, Jr., Fairmont; Jack Leckie, Huntington; J. P. McMullen, Wellsburg; L. J. Pace, Princeton; Maynard P. Pride, Morgantown; W. Hampton St. Clair, Jr., Bluefield; I. Ewen Taylor, Huntington; and Frank J. Zsoldos, Mullens.

PG Course in Internal Medicine

The American College of Physicians will sponsor a course in "Review of Advances in Internal Medicine" in Brooklyn, New York, November 8-12.

Fees are $60 for ACP members and $100 for nonmembers. The sessions will be conducted at Maimonides Hospital of Brooklyn.

Further information may be obtained by writing to the ACP, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

PG Course in Fractures

The American Academy of Orthopaedic Surgeons is sponsoring a postgraduate course on the Treatment of Fractures and Other Injuries in Atlanta, October 11-14.

Registration fee is $75, but no fee will be charged for interns and residents when their registration is accompanied by a letter from their chiefs of service.

Advance registration should be made with Dr. Wood W. Lovell, American Academy of Orthopaedic Surgeons, 29 East Madison Street, Chicago, Illinois 60602.

Amendments to By-Laws Adopted By House of Delegates

The House of Delegates of the West Virginia State Medical Association, at the second session on Saturday afternoon, August 28, adopted a large number of amendments to the By-Laws. The amendments were offered at the first session on Wednesday afternoon, August 25, by Dr. James S. Klumpp of Huntington, Chairman of the Committee on Constitution and By-Laws.

In his report to the House of Delegates, Doctor Klumpp stated that the Committee had made a thorough study of the Constitution and By-Laws during the past year. He said that no major changes had been made since 1959.

Proposed Constitutional Amendments

The following amendments to the Constitution, which were offered by the Committee, will be submitted to the House of Delegates for final action at the 99th Annual Meeting at The Greenbrier, August 25-27, 1966.

(1) Amend Article V, Section 1, by deleting subsection (2) and inserting in lieu thereof "all past presidents of the Association; and,". (The effect of this amendment would be to make all past presidents life-time members of the House of Delegates. Past presidents currently are members of the House for a period of 10 years following their tenure of office).

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(2) Amend Article VIII, Section 2, by deleting the entire Section and inserting in lieu thereof the following: "Section 2. The place and dates for each annual meeting of the Association shall be selected by the Council." (Under the present Constitution, the place for the annual meeting is selected by the House of Delegates and the dates are selected by the Council).

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(3) Amend Article IX, Section 2, as follows: Amend line 1 by inserting after the word, "Councilors," the words, "and the president." (Note: The president is not elected but is installed into office from that of president elect).

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(4) Amend Article IX, Section 4, as follows: Amend line 5 by deleting the word, "president," and inserting in lieu thereof the words, "president elect." (Note: If retiring president cannot be eligible for future election as president or vice president, neither should a past president be eligible for election as president elect).

Amendments to the By-Laws

Amend Chapter I, Section 2, by deleting Section 2 from the present By-Laws and substituting the following as Section 2:

"(a) Disciplinary action may be taken by a component society against a member thereof only upon written charges signed by one or more members of such society and filed with the society's secretary. Within ten days after charges have been filed the secretary shall serve upon the accused member a true copy of such charges, and shall also furnish a Councilor of that District a copy thereof. Thereafter, and at least ten days before any action is taken on such charges by the component society, or by any committee thereof, the secretary shall serve upon the accused a written notice specifying the time and place of the hearing, and shall also furnish a Councilor of that District a copy of said notice. Service upon the accused may be made by personal delivery to the accused or by registered mail to his usual place of residence, with a request for return receipt signed by the addressee.

"At the hearing upon such charges the accused shall be afforded full opportunity to be heard in his own defense, or by counsel, who may or may not be a member of this Association, to cross-examine witnesses, and to examine witnesses and offer evidence in his own behalf.

"A record shall be made of such hearing by a competent reporter, and at the request of either the accused or the component society, the society's secretary shall cause a transcript to be made of the proceedings, evidence and findings. Suspension or expulsion from the component society shall require a two-third's majority of the votes cast.

"(b) Any member who has been censured or who has been suspended or expelled from his component society shall have the right of appeal to the Council of the West Virginia State Medical Association from the order of censure, suspension or expulsion, and the Council shall have jurisdiction to hear and determine such appeal, and to affirm, modify or reverse the order of the component society. Any such appeal shall be on questions of law and procedure only, and not on questions of fact. The appeal must be filed with the Executive Secretary of the Association within sixty days after the date of the component society's order from which the appeal is taken; and with such appeal, the appellant shall file proof that a copy of such appeal has been mailed to or served upon the president or the secretary of the component society from whose order the appeal is taken.

"Within sixty days after the filing of such appeal, the component society shall file with the Council a record of the society's disciplinary proceedings against the appellant, including the original papers, documents, resolutions and minutes, or certified copies thereof, and including a transcript of the proceedings, evidence and findings in connection with the hearing on the charges against the appellant. With such record there shall be filed by the president or secretary of such component society a certificate signed by said president or secretary, certifying that such record constitutes a complete, true and correct record of all the disciplinary proceedings before such component society, and further certifying that written notice of the filing of such record has been mailed to or otherwise served upon the appellant. If the component society fails to file such record within the time allowed, the Council shall restore the appellant to membership in good standing in his component society.

"Following the filing of the record by the society, the Council shall set a date for hearing of the appeal before the Council, and the Executive Secretary shall

give prompt notice thereof to each party. The appeal shall be heard, considered and determined by the Council solely upon the record filed by the society with the Council, and the oral statements of the parties concerned or their counsel. Affirmation, modification or reversal by Council of the orders issued by the component society shall require a two-third's majority of the votes cast.

"In any case where a component society fails to conduct hearings upon charges made against any of its members, the Council may proceed with disciplinary measures in the same manner provided above for component societies; and in any case in which a component society fails to take prompt disciplinary action against one of its members after being requested in writing by the Council of the West Virginia State Medical Association to do so, the Council shall proceed to institute and prosecute such disciplinary action and to enter such order of dismissal or censure, or of suspension or expulsion from the component society, as the evidence adduced at the hearing may warrant."

Amend Chapter I, Section 3 as follows: "Reinsert Section 2 of present By-Laws as Section 3, and renumber Sections 3 and 4 as Sections 4 and 5, in which there are no changes.

Amend Chapter I, Section 6, by renumbering Section 5 as Section 6 and deleting and substituting therefore the following: "The active membership of this Association shall consist of those physicians or doctors of medicine who are actively engaged in the practice of medicine, who hold a degree of Doctor of Medicine, or Bachelor of Medicine, who are licensed to practice medicine in the State of West Virginia, and who are members of one of the component societies in this Association.

"Any active member of this Association who has become physically or mentally incapacitated for any type or degree of medical practice or for medical administrative duties, may, upon nomination by his component society and election by the Council, become an honorary member of this Association. Any member of this Association who, without regard to his physical or mental condition, finds he is financially unable to pay the required dues, may be relieved of all or partial payment upon request to the Council and approval by that body.

"Honorary members shall be exempt from the payment of dues or assessments. They shall have the privilege of the floor in any open session of the Association, but shall not have the right to make or second motions, to vote, or to hold any elective office in this Association, except that they may hold elective or appointive committee membership."

Amend Chapter I, Section 7, by renumbering Section 6 in present By-Laws as Section 7 and amending by deleting the figure, "$50.00," and substituting therefore the figure, "$80.00."

Amend Chapter III, Section 1, by inserting the word, "scientific," after the word, "general," in line 2.

Amend Chapter IV, Section 1, by inserting the word, "annually," after the words, "shall meet," in line 1.

Amend Chapter IV by adding a new section (Section 14) as follows:

"Sec. 14. The House of Delegates shall meet in open session, to which any person may be admitted, except as it may move into closed session, attendance to which shall be restricted to members of the Association, its legal counsel and members of the Association's office staff, and, except that it may move into executive session, restricted to members of the House of Delegates, legal counsel of the Association, and such members of the Association's staff as are necessary for proper functioning of the House. In any session only delegates and authorized official personnel shall have the privilege of the floor, except by unanimous consent."

Amend Chapter IV by adding a new section (Section 15) as follows:

"Sec. 15. The proceedings of any open session of the House of Delegates shall be published in The Journal in the first possible issue following each session."

Amend Chapter V, Section 1 and Section 2, by deleting Sections 1 and 2 from present By-Laws and substituting the following as Section 1:

"Sec. 1. All elections shall be by written ballot, and a majority of the votes cast shall be necessary to elect; provided, however, that when there are more than two nominees for any office, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue until but two candidates remain, and an election occurs; provided, further, if there is but one candidate for the office under consideration the presiding officer may direct a viva voce ballot.

"The officers of this Association and delegates and alternate delegates to the American Medical Association shall be nominated in the method prescribed in that section of the By-Laws relative to the duties of the Committee on Nominations, and they shall be elected during the final session of the House of Delegates at each annual meeting."

(Note: Present Section 3 now becomes Section 2).

Amend Chapter VI, Section 1, by deleting the phrase, "with the exception of the Grievance Committee," beginning on line 7. (Note: The duties of the Grievance Committee were assumed by the Executive Committee

which was created under provisions of another amendment to the By-Laws).

Amend Chapter VI, Section 2, by deleting all of the Section except the first sentence and inserting thereafter the following:

"In the event of the death, resignation, incapacitation or removal from office of the President, the President Elect shall succeed him in office and shall serve for the remainder of the term of his immediate predecessor. If the time so served is less than six months he shall also serve as President until the second annual meeting following his election as President Elect. If he succeeds to the presidency six months or more before the first day of of the following annual meeting, the House of Delegates, at that meeting shall elect another qualified and eligible person to serve as President until the next annual meeting.

"The President Elect shall be installed as President as the final order of business at the final session of the House of Delegates at each annual meeting, and he, with the other elected officers and the Councilors elected at that meeting, shall immediately thereafter assume the duties of their respective offices."

Amend Chapter VI, Section 3, by adding to the first sentence the following: "and shall countersign all checks and vouchers issued by this Association."

Amend Chapter VII, Section 1, as follows: Paragraph 1 in Sec. 1 is unchanged; however, paragraph 2 of Section 1 is to be deleted and the following substituted therefor: "The Council shall be the executive body of the House of Delegates, and between meetings shall exercise all the powers conferred on the House of Delegates by this Constitution and By-Laws. The Chairman of the Council shall submit an annual report of its activities to the House of Delegates." (Note: Simple clarification of present section).

(Paragraph 3 of Section 1 is unchanged).

Amend Chapter VII, Section 3, by deleting the entire Section and inserting in lieu thereof the following: "The Council shall be the Board of Censors of this Association, considering all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. The Council shall have appellate jurisdiction and the power of final decision in all questions of discipline affecting the conduct of members or of a component society. The procedures to be followed shall be as stated in that Chapter of this Constitution and By-Laws referable to membership. All decisions of the Council in such matters shall be binding, except that decisions in procedural processes may be appealed to the Judicial Council of the American Medical Association."

Amend Chapter VII, by adding a new section (Sec. 10): "The State of West Virginia shall be divided into six Councilor Districts with the following geographical limits:

District No. 1—Hancock, Brooke, Ohio, Marshall, Wetzel, Marion and Taylor Counties.

District No. 2—Monongalia, Preston, Barbour, Randolph, Tucker, Grant, Hardy, Mineral, Hampshire, Morgan, Berkeley, Jefferson, Pendleton and Pocahontas Counties.

District No. 3—Pleasants, Tyler, Ritchie, Doddridge, Harrison, Lewis, Gilmer, Calhoun, Clay, Nicholas, Webster, Braxton and Upshur Counties.

District No. 4—Wood, Wirt, Jackson, Roane, Mason, Putnam, Cabell, Wayne and Lincoln Counties.

District No. 5—Mingo, Logan, Wyoming, McDowell, Mercer, Summers, Monroe and Greenbrier Counties.

District No. 6—Kanawha, Boone, Fayette and Raleigh Counties."

Amend Chapter VII, by adding a new section (Sec. 11): "At no time shall two members of the same component society serve concurrent terms as elected or appointed Councilors from their respective Districts."

Amend Chapter VII, by adding a new section (Sec. 12): "The Council shall have the authority to suggest possible nominees for appointment to any state regulatory, administrative or consultative board, commission or committee, when such nominations are requested by competent authority or are required by statute."

Amend Chapter VIII, by deleting all of Section 1 and inserting in lieu thereof the following:

"There shall be an executive committee of this Association, composed of the three immediate Past Presidents, the President, President Elect, Vice President, Treasurer and the Executive Secretary ex officio, with the President serving as Chairman, whose duties shall be as follows:

"(a) The Committee shall exercise general supervisory control over the activities of the Association's executive offices. It shall make suggestions to the Council in regard to salary schedules of all employees, and shall consider and recommend to Council any present or future proposed fringe or retirement benefits, and shall further supervise the operation of all such benefits.

"(b) Prior to January one of each year, the executive committee shall set up an annual budget for consideration and approval by the Council.

"(c) The executive committee shall prepare the agenda for the Council meetings, and shall make recommendations to the Council in regard to any pertinent matters contained therein, but shall not in any way infringe upon the responsibilities or privileges of the President of this Association.

"(d) This Committee shall act as a Grievance Committee of the Association, with the responsibility of hearing complaints made by laymen against any member of this Association. Such complaints may be re-

ferred by component societies, or may be made directly when they cannot be adjudicated at the local level. The Committee shall report to Council their findings and recommendations, and decisions made by the Council shall be final. A report of such findings and recommendations or decisions shall be forwarded to the proper component society and to the District Councilors.

"(e) Nothing contained herein shall in any way curb the powers of Council, acting as a Board of Censors, in matters involving the rights and standing of members as authorized in Chapter VII, Section 3, of these By-Laws."

(Note: (a) Takes over the duties of present Budget and Personnel Committee; and (d) assumes the duties of present committee composed of five immediate Past Presidents as in Section 3—Grievance Committee).

Amend Chapter VIII, by deleting all of Section 2 and inserting in lieu thereof the following (Provides for a revision in the make-up of standing committees of the Association):

"Members of the following standing committees, with the exception of the Publication Committee, shall be appointed by the President from the membership of the Association. Except as may be otherwise provided in these By-Laws, the terms of members of standing committees shall begin with the installation of the incoming President and end at the close of the next annual meeting:

Committee on Aging.
Committee on Cancer.
Committee on Constitution and By-Laws.
Committee on Insurance.
Committee on Legislation.
Committee on Maternal and Perinatal Fetal Welfare.
Committee on Medical Aspects of Sports.
Committee on Medical Economics.
Committee on Medical Education and Hospitals.
Committee on Medical Emergencies and Civil Defense.
Committee on Medical Scholarships.
Committee on Inter-Professional Relations.
(A) Medico-Legal
(B) Medicine-Religion
(C) Medicine-Pharmacy
(D) Medical-Dental
(E) Nurses Liaison.
Committee on Mental Health.
Committee on Military Medical Affairs.
Committee on Nominations.
Committee on Presidential Address.
Committee on Program for Annual Meeting.
Committee on Public Service.
Publication Committee.
Committee on Rehabilitation.
Committee on Resolutions.
Committee on Rural Health.
Committee on Syphilis.
Committee on Tuberculosis."

Amend Chapter VIII, Section 3, by deleting the first paragraph in present Section 2 (which now becomes Sec. 3), and retain the following: "The chairman of each standing committee shall render a report in writing for publication in The West Virginia Medical Journal prior to each annual meeting."

(Note: Delete entire Section 3 from present By-laws which outlines the duties of the Grievance Committee. See explanation in Sec. 1 of this Chapter).

Amend Chapter VIII, Section 5 (Duties of Standing Committees), by adding a last sentence to the first paragraph of the duties of the Committee on Medical Economics as follows: "The Committee shall have membership representing each Councilor District."

Add to Section 5 the duties assigned to the following new standing committees:

"Committee on Inter-Professional Relations. (1) The general committee on Inter-Professional Relations shall be composed of the several sub-committees, each with a sub-chairman, who shall serve under the chairman of the general committee.

"(2) Each sub-committee shall be responsible for maintenance of cordial relations between this Association and the various professions named in these By-laws; they shall exercise such authority as may be assigned to them by Council or by the House of Delegates in the study of mutual problems, negotiations in matters which may involve the different professions, and shall report to competent authority their findings, recommendations and resumé of their activities whenever such report may be indicated."

"Committee on Presidential Address. It shall be the duty of this Committee to review the annual address of the President, with especial attention as to the content and the suggestions and recommendations contained therein, and to report their findings and recommendations to the House of Delegates."

Amend Chapter VIII, by adding a new section (Sec. 7):

"Special committees may be created by the Council or by the House of Delegates in accordance with the terms of the motions authorizing their appointment. All such special committees shall be dissolved upon the termination of their assigned duties."

Amend Chapter IX, Section 5, by deleting the entire Section since the right of physicians to appeal to the Council is already provided for in Chapter I, Sec. 2, of the By-Laws as amended.

(Sections 6, 7, 8 and 9 of present Chapter IX now become Sections 5, 6, 7 and 8 of amended By-Laws).

Amend Chapter X, Section 4, by deleting the word, "usage," in line 2 and inserting the word, "procedure."

Amend Chapter X, by adding a new section (Sec. 6): "During the first session of the House of Delegates at each annual meeting, the executive secretary shall

read the names of all members deceased since the last annual meeting, with the date of demise, after which the presiding officer shall request a moment of silent prayer in their memory."

Amend Chapter X, by adding a new section (Sec. 7): "The following order of business shall be used for meetings of the House of Delegates:

Call to Order.
Reading or Disposition of Minutes of Previous Meeting.
Roll Call of Delegates.
Reports from Council.
Reports from Standing Committees.
Reports from Special Committees.
Unfinished Business.
New Business.

"The Presidential Address and introduction of honor guests, when so ordered by the Program Committee, shall be delivered after roll call at one session during each annual meeting.

"The President Elect shall be installed as President as the last item of new business at the final session of the House of Delegates at each annual meeting."

Amend Chapter XI, by adding a new section (Sec. 2):

"Whenever an amendment to the By-Laws has been made, it shall be the duty of the Executive Secretary to notify the secretary of each component society within sixty days after it has become effective. It shall be incumbent upon each component society to make such changes in its constitution and by-laws, or if the society be a corporation, in its code of regulations or other fundamental body of rules for the government of the corporation, as will bring about conformity to the change in the By-Laws of the West Virginia State Medical Association. Written notice of this compliance shall be sent to the Executive Secretary within six months of such notice."

J. P. McDevitt Reelected President Of TB and Health Assn.

Jerome P. McDevitt of Princeton was reelected President of the West Virginia Tuberculosis and Health Association during the organization's annual meeting in Huntington on September 16.

Also reelected were the following officers: Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President; Mr. H. D. Rohr of Weston, Secretary; and Winton R. Houck of Charleston, Treasurer.

Elected to the Executive Committee were Oscar J. Andre of Clarksburg, Mrs. Lela House of Williamstown, Dr. John J. Lawless of Morgantown, Mrs. R. S. Meighen of Weirton, and John Shott of Bluefield.

Gov. Hulett C. Smith had been scheduled to speak at the convention. but was forced to cancel because of a conflict with the Southern Governors Conference meeting.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1965

Oct. 1-2—W. Va. Chapter, ACS, Morgantown.
Oct. 7-9—ACP, Miami Beach.
Oct. 8-10—W. Va. Div., Am. Cancer Soc., Wheeling.
Oct. 10-13—Medical Soc. of Virginia, Richmond.
Oct. 13-15—W. Va. Nurses Assn., Pt. Pleasant.
Oct. 15-19—American Heart Assn., Bal Harbour, Fla.
Oct. 15-22—Col. of American Pathologists, Chicago.
Oct. 18-22—ACS Clinical Cong., Atlantic City.
Oct. 23-27—Am. Soc. of Anesthesiologists, Denver.
Oct. 23-28—Am. Acad. of Ped., Chicago.
Oct. 24-27—Am. Col. of Gastroenterology, Bal Harbour, Fla.
Oct. 27-29—American Cancer Soc., New York.
Oct. 29-31—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical Assn., Houston.
Nov. 14-19—American Acad. of Oph. & Otol., Chicago.
Nov. 27-28—ACCP, Philadelphia.
Nov. 27-Dec. 3—Radiological Soc. of N. America, Chicago.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Feb. 1-5—Am. Col. of Radiology, Chicago.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 1-7—AAGP, Boston.
April 13-16—Am. Radium Soc., Phoenix.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
April 25-28—Industrial Med. Assn., Detroit.
April 25-29—Am. Col. of Allergists, Chicago.
April 26-29—Am. Acad. of Ped., Bal Harbour, Fla.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 10-14—ACS, San Francisco.

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References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

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WVU Medical Center
—News—

TWENTY-SEVEN persons are listed among the new faculty members in the West Virginia University School of Medicine.

They, their last places of employment (clinical professors excepted) and present positions are:

Drs. Robert Brossman (WVU), part-time instructor in anatomy; David Williams (Medical College of Georgia), assistant professor of anatomy; Allen Morehart (University of Oklahoma), assistant professor microbiology; Erlo Roth (Armed Forces Institute of Pathology), assistant professor of pathology.

Michael Wilson (University of Kentucky), chairman of physiology; Albert Pugh (Veterans Administration Hospital, Clarksburg) clinical associate professor of internal medicine; Gwendolyn Hogan (Harvard Medical School), assistant professor of neurology and pediatrics; Philip Sprinkle (University of Virginia), chairman of otolaryngology; Stanley Shane (WVU), assistant professor of internal medicine; Gale Rafter (John Hopkins Hospital), assistant professor of biochemistry.

Paul Benoit (Creighton University), assistant professor of anatomy; James Martin (Harvard), assistant professor of neurology; Robert McCafferty (University of Kentucky), associate professor of anatomy; Samuel Katz (Naval Medical Research Institute), assistant professor of biochemistry; Joseph R. Lancaster, Jr., (University of Chicago), assistant professor of surgery; Marilyn Butler (Los Angeles City Schools), instructor in medical technology; Hushang Payan (VA Hospital, Clarksburg), clinical assistant professor of pathology; Thomas Snyder (VA Hospital, Clarksburg), clinical instructor in medicine.

Robert Stitzel (University of Minnesota), assistant professor of pharmacology; Garnet Bradley(Fairmont Clinic), clinical associate professor of psychiatry; Arthur Bryant (VA Hospital, Clarksburg), clinical assistant professor of psychology; Peter Chang (St. Francis Hospital, Wilmington, Del.), instructor in anesthesiology; Frank Crain (WVU), instructor in biochemistry; William Jacobs (VA Hospital), instructor in medicine; Francis Januszeski (St. Mary's Hospital, Clarksburg), clinical assistant professor of pathology; German Lizarralde (WVU), instructor in surgery; and Baljit Nanda (WVU), instructor in anatomy.

Surgeons Meet at Medical School

Two guest speakers will be featured at a meeting of the West Virginia Chapter of the American College of Surgeons on Friday and Saturday, October 1-2, at the WVU Medical Center.

• Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.

They are Drs. Mark M. Ravitch, Professor of Surgery at The Johns Hopkins Hospital in Baltimore, and Albert J. Paquin, Jr., Chairman of the Department of Urology at the University of Virginia School of Medicine.

Doctor Ravitch will discuss the newer aspects of treatment of omphalocele in the newborn and the application of mechanical stapling devices to general and thoracic surgery. In his papers, Doctor Paquin will talk on the surgical management of disorders of the ureterovesical junction and also the epidemiologic and experimental aspects of urinary tract infections.

Papers also will be presented by members of all divisions of the Department of Surgery in the West Virginia University School of Medicine.

Scientific sessions will be held both days in the main auditorium at the WVU Medical Center. Topics will be of interest to both general surgeons and surgical specialists.

A social program will be held at the Holiday Inn on Friday evening. The next day, participants will take in the WVU-Pitt football game.

October Lecture

A lecture on "The Role of RNA in the Regulatory Action of Estrogen" will be given October 25 at the Medical Center.

It will be delivered by Dr. Sheldon J. Segal, director of The Population Council, Rockefeller Institute, New York. The lecture will be under sponsorship of the WVU Institute of Biological Sciences.

Doctor Watne Receives Grant

The American Cancer Society has awarded Dr. Alvin L. Watne of the West Virginia University School of Medicine an Institutional Research Grant of $18,750.

Doctor Watne's grant was among 178 totaling $5,066,549 made by the ACS in a new allocation throughout the country.

Dr. Bernard Zimmermann of the WVU School of Medicine, President of the West Virginia ACS Division, said the Society approved 60 new grants amounting to $1,725,542 and 118 renewals totaling $3,341,007 for continued support of research already in progress.

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The Month in Washington

DESPITE the flood of major health measures approved by Congress this year, President Johnson apparently plans to propose more important health legislation next year. It appears that health has been given No. 1 priority on the "great society" program.

Johnson has been telling Congressmen to think in terms of even greater strides next year. To lay the groundwork for new legislation, he has called a White House Conference on Health in Washington, November 3-4.

Johnson recently took the occasion of signing two health bills to outline his health goals:

—An increase in the average life expectancy from the present 70 years to 75 years.

—A reduction in infant mortality from the present rate of 25 deaths per 1000 births to 16 per 1000.

Virtual elimination of polio, diptheria and typhoid fever and an end to tuberculosis, measles and whooping cough.

—A reduction of 20 per cent in deaths from heart disease, cancer and stroke—the so-called "killer diseases" that now account for one-third of all deaths in the United States.

—Elimination of death and disability among children caused by rheumatic fever and rheumatic heart disease.

—Eradication of malaria and cholera from the entire world.

One of the two health bills he signed into law authorizes a three-year, $280 million extension of the Health Research Facilities Act. It also authorizes three additional Assistant Secretaries of HEW, one for Health and Medical Affairs. A special assistant to the secretary had been the top official for Health and Medical Affairs.

Vaccination Assistance Act

The other bill amends the Vaccination Assistance Act and extends it for five years. It authorizes Federal expenditures of $8 million a year, broadens the program to include measles and any other disease designated by the Surgeon General of the Public Health Service and makes the immunization program a continuing one, rather than "an intensive community vaccination (program) of limited duration." Expenditure of $45 million during the next five years also is authorized for family health clinics for migratory workers.

Neither the chairman nor the vice chairman of the White House Conference on Health is a physician.

• **From the Washington Office of the American Medical Association.**

However, five of the nine members of the executive committee to plan for the conference are physicians. All were appointed by Johnson.

George Beadle, Ph.D., president of the University of Chicago, will be chairman and Boisfeuillet Jones, former special assistant to the HEW Secretary, vice chairman.

Five Physicians on Committee

Physicians on the executive committee are Drs. Dwight L. Wilbur of San Francisco, a member of the AMA Board of Trustees; George James, New York health commissioner; Lowell T. Coggeshall, trustee and former dean of the Medical School, University of Chicago; Montague Cobb, professor of anatomy, Howard University Medical School and former president of the National Medical Association, and Michael E. DeBakey, professor of surgery, Baylor University.

The chief executive said the purpose of the conference is to bring together "the best minds and the boldest ideas to deal with the pressing health needs of the nation." He said he hopes the conference will develop "creative programs that will bring better health to every American."

New FDA Proposals

The Food and Drug Administration issued two proposals designed to eliminate possible causes of illness. One called for a reduction in the amount of vitamin D added to food products and the other for pasteurization of commercial egg products.

Last November Dr. Robert Cooke of Johns Hopkins University expressed concern that the ingestion of excessive amounts of vitamin D was a possible cause of infantile hypercalcemia. FDA Commissioner George P. Larrick then invited the Committee on Nutrition of the American Academy of Pediatrics and a Joint Committee of the Council on Foods and Nutrition and the Council on Drugs of the American Medical Association to look into this problem.

Both committees recommended that, while there has been no positive demonstration of a cause and effect relationship of vitamin D to this disease, there should be restrictions on the marketing of foods containing added vitamin D.

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DOSAGE: Children—six years or over—One teaspoonful three times daily for 3 days.

CAUTION: Drowsiness may occur. Use only with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

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Annual Reports *

Presidential Address

In his annual address to the House of Delegates of our Association, the President has given us a concise review of the events which have developed over the past three decades, and have culminated in the historic passage of social welfare legislation best known as Medicare, a compulsory socialistic venture which asserts that basic human rights can best be guaranteed by a federally controlled tax system; a system that compels all older citizens to accept government largess, without any regard for individual need, at the expense of a working population, whose tax burden will become more onerous as the years go by.

He has told us, as we all must realize, not only the immediate changes which will affect our profession and the general public, but he has also charted what the future course of such legislation will likely produce. It has been freely admitted by proponents thereof, that Public Law 89-97 is but a foot in the door, and the political activities of liberals, labor-leaders and non-thinking socialistic persons will surely result in further encroachment upon our individual and group freedoms, to the end that complete socialization of our nation may ensue.

The President cited the difficulties in developing an efficient brake on these trends, but assured his audience that socialism can and must be stopped if we are to survive as a free people. He stated the need for improving our public image, making certain that our ideas are fairly and honestly communicated to the public and, most vital of all, the assumption of leadership in our various civic and political communities, in the struggle to return political, social and economic freedom to those who so deserve and are willing to fight for a reversion from socialism to democracy.

In his address, the President made pertinent reference to the rising costs of hospital care and to our responsibilities in that area. He stressed the need for full use of our facilities for medical education and recommended an extension of these into an area of larger population. Perhaps one item which may evoke considerable discussion was Doctor Esposito's recommendation that we reevaluate our concept of a combined Blue Cross-Blue Shield Plan as a lead toward possible separation of these two facilities.

The Committee concurs in the President's recommendation that a physician's advisory committee be appointed for liaison with state authorities on Hill-Burton financial commitments.

The Committee feels that our membership will be pleased to learn of the proposed revision of fee schedules for services rendered to GMH and MAA clients.

Your Committee earnestly suggests that Doctor Esposito be deeply commended for his interest and efforts in our behalf, and that an expression of such gratitude shall be evidenced by a standing vote of thanks.

Respectfully submitted,

J. C. Huffman, M. D.,
Chairman.
Richard W. Corbitt, M. D.
Charles L. Goodhand, M. D.
James S. Klumpp, M. D.
I. Ewen Taylor, M. D.

*Other annual reports were published in the August 1965 issue of The Journal.

Insurance Committee

November 1 marks the eighteenth anniversary of the establishment of the West Virginia State Medical Association Group Insurance Program. Our State Association was one of the first in the country to sponsor group insurance for the benefit of our members. Today, we have by any measure one of the most successful programs in the nation. Our members are offered a wide range of plans, all firmly established and in sound operating order. Continental Casualty Company, underwriter of our program, advises that the broad selection of plans equals or exceeds any it knows of in the industry.

The foundation of the program, of course, is the Monthly Income Disability Plan. This is true career type coverage and contemplates serious long-term disability.

Other plans available include the $10,000 family Major Medical Policy, the Office Overhead Policy, the $1 Million Catastrophe Liability Policy, the $100,000 Accidental Death and Dismemberment Policy; and finally and perhaps most important, the Wes-Trust Plan. Wes-Trust is a retirement investment program providing a unique combination of common stock and group annuity. At the time of retirement a member at his option may take a monthly income guaranteed for life, leave his savings invested for future growth and appreciation, or take cash. Trustee for the plan is the Charleston National Bank. We obtain qualified investment management at a minimum cost.

A very important development of the past year is the extension of the $100,000 Accidental Death and Dismemberment Policy. The new policy provides that when a member is totally and permanently disabled by accident, the policy pays at the end of 12 months of such disability the face amount of the policy.

Another important development is the extension of the present life insurance program. The new life plan will provide up to $40,000 of life insurance in $10,000 increments. This low-cost coverage offers a significant addition to your life estate at a very low cost. It is certainly worthy of your most serious consideration.

It should be noted that the Association is the recipient of a letter from the Continental Casualty Company advising that our Association is one of a select group of programs the company underwrites providing complete administration. Functions include the processing of applications, billing and collecting of premiums, and the supervision and payment of claims is performed by our Resident Administrator located here in the state. A Service Representative travels

the state and is always available for consultation, and to assist when necessary in the filing of claims. The advantage of the wide scope of coverage at low group rates, and service here in the state cannot be overestimated.

Members of the committee in addition to the chairman are Drs. W. P. Bittinger, C. Stafford Clay, C. R. Davisson, John E. Echols, Upshur Higginbotham, Charles L. Leonard, Athey R. Lutz, Richard V. Lynch, Jr., Joe E. McCary, Eldon B. Tucker, John L. Van Metre, Gates J. Wayburn and Lynwood D. Zinn.

Respectfully submitted,

C. A. Hoffman, M. D.
Chairman

August 26, 1965.

Medical Education and Hospitals

The Committee on Medical Education and Hospitals of the West Virginia State Medical Association met twice in 1965, first on April 11 and then on July 18. Both meetings were conducted at the Daniel Boone Hotel in Charleston.

The principal recommendation that the Committee has to make at this time concerns the establishment of medical education workshops in West Virginia. At its July 18 meeting, the Committee approved the recommendation in the following form:

Problems

1. Undergraduate, intern and resident, and postgraduate or continuing medical education have become widely separate endeavors with insufficient attempts at establishing a system of coordination or continuity.

2. Unrest regarding intern-resident and continuing education programs is prevalent.

3. Many organizations and societies are represented in this area of medical education—medical schools, community hospitals, the AMA, specialty societies, colleges and associations and voluntary and public health agencies.

4. Specific curricula should be coordinated in the light of community needs with economy of time and available resources.

Recommendations

The American Medical Association and the Association of American Medical Colleges have called upon the state associations and the area medical schools to recognize and respond to this failure to meet the community needs. They have encouraged closer association between the medical schools and practicing physicians to share mutual educational needs at all levels, including preceptorships. This would in fact be a "University Without Walls," which is in agreement with the basic or "core" curriculum for continuing education being developed by the AMA.

The Council on Medical Education of the AMA and the Association of Medical Colleges are active in the establishment of subject committees to formulate basic or "core" curricula for continuing education in the various fields of medical practice. The Committee on Medical Education and Hospitals of the West Virginia State Medical Association recommends that similar subject committees be established at the state level.

Each subject committee should include at least one representative from (a) the West Virginia State Medical Association, (b) the West Virginia Chapter of the American Academy of General Practice, (c) the appropriate specialty organization, (d) the teaching hospitals of the state, and (e) the West Virginia University School of Medicine. The President of the West Virginia State Medical Association shall appoint the representative from that organization, and the West Virginia University School of Medicine, the appropriate specialty organization and the West Virginia Chapter of the American Academy of General Practice shall be invited to appoint their representatives. The teaching hospital representative on each committee shall be selected by the other committee members from a list of names submitted by the hospitals.

Each subject committee should correlate its activities with its national counterpart, modifying or initiating programs to meet local needs. Each subject committee shall establish a small number of hospital-oriented regions throughout the state to implement its educational program.

Workshops

The first workshop shall be composed of members of the Committee on Medical Education and Hospitals of the West Virginia State Medical Association and the State Medical Association's representative on each of the subject committees. This would be followed by a series of workshops involving each of the subject committees to proceed with implementation of the program.

Each subject committee shall select its own chairman, who shall report to the Committee on Medical Education and Hospitals in order that it might coordinate the over-all program.

It is suggested that the Committee on Medical Education and Hospitals may receive counseling service from the Curriculum Committee of the West Virginia University School of Medicine, representatives from the state's hospitals DME's and any state professional and voluntary health agency.

The Committee on Medical Education and Hospitals wishes to stress that *participation* by *all* physicians is the key to continued learning.

* * * *

The Committee spent considerable time discussing intern and residency programs in hospitals in the State. It was pointed out that 21 of the 57 students who received M. D. degrees in June from the School of Medicine will intern in West Virginia hospitals. Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, said several students who have accepted internships elsewhere stated they plan to return to West Virginia upon completion of their training.

Doctor Sleeth recited figures relative to enrollment at the WVU School of Medicine. He said his office

had received 326 formal applications for admittance to the first year class beginning in September, 1965. One hundred twenty-five of these were from West Virginia students. Sixty-four West Virginians were offered places in the incoming class and 49 accepted. Doctor Sleeth observed that the School's attrition rate is good, that it lost only seven of 239 students last year. These included one member of the third year class and one member of the fourth year class. Six other students are making irregular progress and it may take them five years to finish their medical education. Doctor Sleeth said the Medical School has graduated 157 physicians, about 20 of whom are now practicing in West Virginia.

The Committee recommends that steps be taken to increase the number of medical and ancillary graduates in West Virginia.

(This report supplements an earlier one, which was published in the August 1965 issue of *The Journal.*)

Respectfully submitted,

Pat A. Tuckwiller, M. D.
Chairman

August 25, 1965.

Tuberculosis Committee

The Tuberculosis Committee of the West Virginia State Medical Association has not met this year; however, this does not mean that the problem of tuberculosis does not exist in our State.

The last available statistics in 1963 revealed the death rate for the United States from tuberculosis was 4.9 per 100,000 population. The rate in West Virginia was 8.4. According to reports from the West Virginia State Department of Health more cases have been reported in 1965 than in a comparable period of 1964. Only one neighboring state has a higher death rate. In 1957, only one neighboring state had a lower death rate.

In December 1964 a meeting was called by the State Director of Health to discuss the control of tuberculosis in West Virginia. Members of this committee were invited to attend, but the meeting was cancelled as personnel from the USPHS were unavailable to meet at that time. As far as I know no meeting has been scheduled since by the West Virginia State Department of Health. For the year 1964-65 the state of West Virginia has been granted $85,984 for special project grants and $37,400 in formula grant allocation by the USPHS for use in tuberculosis control.

The West Virginia Tuberculosis and Health Association, the West Virginia University School of Medicine, and your committee have all expressed a willingness to cooperate in more rigid control of tuberculosis.

Respectfully submitted,

William L. Cooke, M. D.,
Chairman.

Charleston,
June 17, 1965.

Necrology Committee

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

	1964	
July	20—J. E. Johnson	Williamson
Sept.	22—Colin Arthur Anderson	St. Marys
Sept.	23—James Clark Killey	Roanoke, Va.
Oct.	5—John Foster Lehman	Kingwood
Oct.	10—J. E. Wilson	Clarksburg
Nov.	1—Joseph Bell Palmer	Wellsburg
Nov.	14—Reuben Richard Louft	Charleston
Nov.	22—Richard Camden Starcher	Ripley
Nov.	25—Charles G. Merriam	Page
Dec.	4—Leo Howard Mynes	Charleston
Dec.	13—Edwin O. Vaughan	St. Albans
	1965	
Jan.	1—Robert B. Grimm	Cameron
Jan.	7—Wylie H. Cunningham	Beckley
Jan.	7—James McClung	Richwood
Jan.	9—D. G. Preston	Lewisburg
Jan.	29—A. L. Jones	Wheeling
Feb.	24—Paul E. Totten	St. Albans
Feb.	25—S. F. Yoho	Moundsville
Feb.	25—Harold D. Gunning	Fairlea
Mar.	9—James L. Cunningham	Pickens
Apr.	10—Wade H. St. Clair	Bluefield
Apr.	12—Joseph Edward Rucker	Roanoke, Va.
Apr.	24—Roy G. Conrad	Weirton
May	15—Norman Randolph Price	Marlinton
May	15—John Paul Trach	Fairmont
May	16—Howard T. Phillips, Jr.	Wheeling
June	2—Robert Wood Dailey	Romney
June	7—Charles T. St. Clair, Jr.	Bluefield
June	14—William J. Hrutkay	Bradford, Ohio
July	9—B. V. Blagg	South Charleston
July	16—Helen M. Belknap Fraser	Louisville, Ky.
July	19—James William Skaggs	Nitro
Aug.	5—Martin Loxley Bonar	Charleston
Aug.	14—Orman Crawford Campbell	Hamlin

Respectfully submitted,

William F. Beckner, M. D.
Chairman

August 25, 1965.

Resolutions

Resolutions offered at the first session of the House of Delegates on Wednesday afternoon, August 25, 1965, were referred to the Committee on Resolutions for study and report back, with recommendations, at the final session on Saturday afternoon, August 28.

Dr. Maynard P. Pride of Morgantown, the Chairman, presided at a meeting of the Committee which was held on Thursday afternoon, August 26.

As recommended by the Committee, the House of Delegates adopted the following resolutions:

Resolution No. 1. Third Party Review Committee—By the Kanawha Medical Society.

BE IT RESOLVED, That there shall be a subcommittee of the Medical Economics Committee designated as a Third Party Review Committee which shall have as its responsibility the review of all third party programs having service policies covering maximum annual income groups, and to make recommendations in regards to the maximum annual income of the individuals and families to be covered under such service policies, and the fees for service rendered to these recipients; and

BE IT FURTHER RESOLVED, That such recommendations shall be presented to the House of Delegates of the West Virginia State Medical Association at each annual meeting for its consideration, ratification or alteration; and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association shall approve only third party programs having service policies covering average annual income groups which pay the usual and customary fee for physician services; and

BE IT FURTHER RESOLVED, That all other programs not conforming to these standards shall be considered as indemnity programs in their coverage of physicians' services; and

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association will continue to maintain a sub-committee of the Medical Economics Committee to negotiate any grievances in regards to the fee for physician services rendered to recipients of all third party programs.

* * * *

Resolution No. 2. Blue Shield as Intermediary Under Medicare—By the Council.

WHEREAS, The Blue Shield Plans are nonprofit, physician approved, community-oriented plans, which are providing medical-surgical benefits to 56 million members, including 6 million elderly citizens; and

WHEREAS, Blue Shield enjoys the active participation of more than 150,000 practicing physicians, including those in West Virginia; and

WHEREAS, Blue Shield is uniquely organized to maintain close working relationships with the medical profession at the local level, and with the American Medical Association at the national level through the National Association of Blue Shield Plans; and

WHEREAS, Blue Shield has demonstrated its ability to implement broad national programs, such as the American Medical Association's resolution in 1958 calling for the development of medical care coverage for the elderly by voluntary means, and the Federal Employee Health Benefit Program.

RESOLVED, That the West Virginia State Medical Association go on record as advocating that Blue Shield act as the intermediary in the medical-surgical section, Plan B, of Public Law 89-97 (HR 6675); and be it further

RESOLVED, That the West Virginia State Medical Association work closely with Blue Shield in the implementation of Public Law 89-97 in West Virginia to insure that maximum freedom is maintained for the medical profession under the Medicare Program; and be it further

RESOLVED, That the West Virginia State Medical Association communicate its decision to have Blue Shield act as the intermediary to the American Medical Association and to the U. S. Department of Health, Education and Welfare; and be it further

RESOLVED, That the West Virginia Delegates to the American Medical Association be instructed to request the House of Delegates of the American Medical Association to endorse the principles contained in this resolution.

* * * *

Resolution No. 3. Separation of Blue Cross-Blue Shield Plans—By the Council.

WHEREAS, It has been the policy of the physicians of our State to endorse the principles of a united Blue Cross-Blue Shield type plan throughout the various areas of the State for many years; and

WHEREAS, In recent years it has become more and more obvious that the policies and desires of Blue Cross, the hospital plan, do not in toto reflect the desires or policies of the physicians in the active practice of medicine in West Virginia or elsewhere; and

WHEREAS, It is believed such a separation of the two plans would prove advantageous to policyholders;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association recommend to the various Blue Cross-Blue Shield plans throughout our State that they explore the possibility of the separation of these plans into a separate Blue Cross and a separate Blue Shield plan, to be sold to the public as separate entities and to be administered as entirely separate entities; and

BE IT FURTHER RESOLVED, That we instruct our delegates to the American Medical Association to present this resolution at the Clinical Convention of the AMA in Philadelphia in November, 1965, and that a copy of the resolution be sent to National Blue Cross and Blue Shield, and to all the executive secretaries of state medical associations throughout the United States.

* * * *

Resolution No. 4. Privileged Communication Between Physician and Patient—By the Council.

WHEREAS, At the present time under Chapter 50, Article 6, Section 10 of the West Virginia Code, communication between physician and patient is privileged only in Justice of the Peace cases; and

WHEREAS, No statute exists in this State governing testimony of physicians and surgeons in courts of record; and

WHEREAS, It is deemed an absolute necessity that the privilege extended under Chapter 50, Article 6, Section 10 of the West Virginia Code, which privilege applies only in Justice of the Peace cases, be extended to all courts of record in the State of West Virginia;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association petition the Governor, the West Virginia Legislature, the West Virginia State Bar and the West Virginia Bar

Association to amend the West Virginia Code to extend the privilege granted to physicians and surgeons under Chapter 50, Article 6, Section 10 of said Code, to all courts of record in the State of West Virginia.

Report of Resolutions Committee

The Chairman of the Committee, Dr. Maynard P. Pride, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 28, 1965. The report follows:

Your Committee on Resolutions has carefully considered the resolutions offered before the first session of the House of Delegates on Wednesday afternoon, August 25, 1965.

Several members of the Association appeared at a meeting of the Committee held on Thursday afternoon, August 26, 1965, and discussed in detail the resolutions pending before the Committee. The cooperation of these physicians has been most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearing.

Mr. President, your Committee assures the members of the House of Delegates that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions were or would be to the best interests of the entire medical profession in West Virginia.

Mr. President, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on August 26, 1965.

Your Chairman personally expresses his gratitude to the members of the Committee for the patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions.

In addition to your Chairman, the members of the Committee participating were Drs. Charles L. Goodhand, Parkersburg; J. C. Huffman, Buckhannon; Charles L. Leonard, Elkins; Kenneth G. MacDonald, Charleston; and I. Ewen Taylor, Huntington; and William H. Lively, secretary ex officio.

UNITED

Obituaries

ORMAN C. CAMPBELL, M. D.

Dr. Orman C. Campbell, 63, of Hamlin, died August 14 in a hospital in Princeton.

Doctor Campbell, who had practiced medicine for 40 years, attended West Virginia University and received his M. D. degree in 1926 from the Medical College of Virginia in Richmond. He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

He was married in 1942 to the former Anne Smith, who preceded him in death.

Survivors include three sisters, Mrs. Grace Richards of Princeton; Mrs. Nell C. Porter of Appalachia, Virginia; and Mrs. J. Ed. Carter of Bluefield.

* * * *

OWEN A. GROVES, M. D.

Dr. Owen A. Groves of St. Petersburg, Florida, formerly of Summersville and Charleston, died September 10 in St. Petersburg following an extended illness. He was 53.

Doctor Groves was born in Summersville and attended West Virginia University before receiving his M. D. degree in 1937 from the Georgetown University School of Medicine.

He was a retired Lieutenant Colonel in the Air Force, having served as a Flight Surgeon. He worked with the West Virginia Department of Health before World War II.

Doctor Groves was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

Survivors, in addition to the widow, include: his father, Harrison Groves of Summersville; a brother, John Harrison Groves of Summersville; and four sisters, Mrs. Thelma Pugh, Mrs. Margaret Savilla and Mrs. Alfreda Wilde, all of Summersville, and Mrs. Louise Still of Winston-Salem, North Carolina.

* * * *

CHARLES ROYAL KESSEL, M. D.

Dr. C. R. Kessel, 71, died of a cerebral hemorrhage September 6 while working at the Kessel Clinic in Ripley which he had founded.

Doctor Kessel took an active part in community affairs. He was a former mayor of Ripley and at the time of his death was Coroner and Health Officer of Jackson County, and a member of the State Commission on Aging.

A native of Given in Jackson County, Doctor Kessel attended Fairmont State College and West Virginia University. He received his M. D. degree in 1921 from Jefferson Medical College.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Ruby Staats Kessel; two sons, Charles Enoch and Dr. James, both of Ripley; his mother, Mrs. Louise Kessel of Ripley; one daughter, Mrs. Betty Louise McLaughlin of Mount Lebanon, Pennsylvania; and two brothers, Dr. Ray of Ripley and Dr. Russel of Charleston.

OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Ernest G. Guy	Philippi	A. Kyle Bush	Philippi	3rd Thurs.
Boone	Harold H. Howell	Madison	David E. Wallace	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	W. R. Wilkinson	Huntington	Harold N. Kagan	Huntington	2nd Thurs.
Central West Virginia	I. F. Hartman	Buckhannon	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	C. V. Townsend	Martinsburg	2nd Wed.
Fayette	Ivan H. Bush, Jr.	Oak Hill	W. P. Bittinger	Oak Hill	1st Wed.
Greenbrier Valley	Robert G. Shirey	Lewisburg	Claude L. Houck	Lewisburg	2nd Wed.
Hancock	J. L. Thompson	Weirton	George S. Kosar	Weirton	2nd Tues.
Harrison	A. Robert Marks	Clarksburg	James A. Thompson	Clarksburg	1st Thurs.
Kanawha	Edward Jackson	St. Albans	Jerill D. Cavender	Charleston	2nd Tues.
Logan	Lyle H. Boyea	Man	Kwan Ho Lee	Logan	2nd Wed.
Marion	W. T. Lawson	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	3rd Tues.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	J. Hunter Smith	Welch	David J. Skewes	Welch	2nd Wed.
Mercer	Sam Milchin	Bluefield, Va.	John J. Mahood	Bluefield	3rd Mon.
Mingo	Enoch W. White, Jr.	Red Jacket	L. Lake Swigart	Williamson	2nd Wed.
Monongalia	George A. Curry	Morgantown	Wm. E. King	Morgantown	1st Tues.
Ohio	Warren D. Leslie	Wheeling	A. M. Valentine	Wheeling	4th Tues.
Parkersburg Academy	E. B. Holmes	Parkersburg	Delmer J. Brown	Parkersburg	1st Thurs.
Potomac Valley	Beverly N. Chambers	Moorefield	Robert W. Bess, Jr.	Piedmont	2nd Wed.
Preston	John W. Trenton	Kingwood	C. W. Moser	Kingwood	4th Thurs.
Raleigh	Warren D. Elliott	Beckley	W. W. McKinney	Beckley	3rd Thurs.
Summers	Buford W. McNeer	Hinton	Jack D. Woodrum	Hinton	3rd Mon.
Taylor	Paul P. Warden	Grafton	Herbert N. Shanes	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	N. Martinsville	Monthly
Wyoming	Frank J. Zsoldas	Mullens	Ross E. Newman	Mullens	Quarterly

County Societies

FAYETTE

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the Fayette County Medical Society which was held in the library of Laird Memorial Hospital in Montgomery on September 8.

Doctor Parks told more than 15 doctors present that the State Medical Association is ready and willing to help county societies resolve their problems. He also said more vigorous recruiting techniques are needed to attract more doctors into rural practice.

A question and answer period touched on such subjects as Medicare and recent discussions with the State Department of Welfare.

Dr. Ivan H. Bush of Oak Hill, President of the Society, presided at the meeting.—W. P. Bittinger, M. D., Secretary.

* * * *

HARRISON

Dr. Edmund B. Flink of Morgantown was the guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on September 2.

Doctor Flink, Professor and Chairman of the Department of Medicine at WVU, presented an informative paper on "Diabetic Retinopathy." He used color slides to illustrate his presentation and a question and answer period followed.

Dr. Richard K. Hanifan, President of the Society, presided at the meeting which was attended by more than 25 doctors from Harrison County and the surrounding area.

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The American prescription drug industry is characterized by unusually high research expenditures. From the time a promising compound is first examined in a research laboratory until the time it may finally be marketed, an average of five or six years of work are likely to be involved.

The cost of research and development of a single new drug has been estimated to average about $5 million. Money is, of course, also spent on promising new drugs which are ultimately discarded and never reach the market for one reason or another. For the drug industry as a whole, the odds are more than 6,000 to one that a newly discovered drug will never reach the market.

In spite of these odds, the American drug industry has discovered, developed and marketed nearly two-thirds of the 604 new drugs made available worldwide since 1941.—Austin Smith, M. D., to Subcommittee on Patents, Trademarks and Copyrights of Senate Judiciary Committee.

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G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
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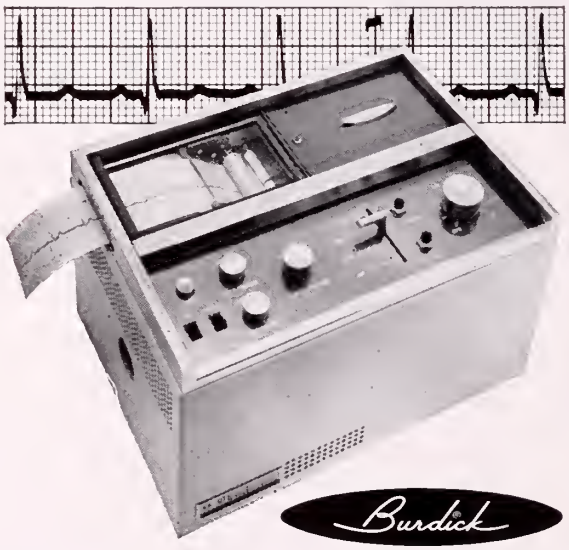

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Book Reviews

PHYSICAL EXAMINATION OF THE JOINTS—By William P. Beetham, Jr., M. D., Howard F. Polley, M. D., Charles H. Slocumb, M. D., and Walt F. Weaver, M. D., Mayo Graduate School of Medicine, Rochester, Minnesota. Pp. 198 with illustrations. W. B. Saunders Company, Philadelphia and London; 1965. Price: $7.50.

This is a short monograph, 192 pages, by four outstanding rheumatologists of the Mayo Clinic.

The book contains a long and official classification of arthritis and rheumatism that is helpful in placing any joint ailment in its proper category. The normal joint is described and classified and there is a chart for recording joint examination.

Chapters 2-12 inclusive deal with anatomy and examination of joints. The latter is expressed under the headings-inspection, palpation, movement and range of motion. There is a chapter concerning the temporomandibular joint and seven chapters describing the joints of the upper extremities. One chapter is devoted to the spinal column and three chapters to the lower extremities.

This is a useful little book. Arrangement and print are excellent and illustrations are very informative. Any physician who is interested in rheumatism and arthritis will find it helpful.

* * * *

SURGERY IN WORLD WAR II (THORACIC SURGERY, VOLUME II)—Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, The Surgeon General, United States Army. Editor for Thoracic Surgery, Frank B. Berry, M. D. For sale by The Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

The second volume of the two volume series on thoracic surgery prepared in the U. S. Army series on Surgery in World War II is a comprehensive review of experience obtained by a competent group of thoracic surgeons who dealt with these problems in specialized centers during World War II. The book is divided into three parts—special types of wounds of the chest, complications of wounds of the chest, and observation on wounds and diseases of the chest in the zone of interior.

The first part deals with the physiologic principles involved in the management and therapy of thoracic wounds, wounds of the heart, and thoraco-abdominal wounds. The specific physiologic disturbance produced by wounds of the various organs is reviewed by word and illustration and would be valuable not only to the specialized surgeon dealing with thoracic problems, but even to the medical student who would like to know more about the principles involved in pneumothorax, hemotharax, great vessel injury, cardiac wounds and thoraco-abdominal wounds. This is especially true since many of the principles evolved during the second world war help to determine our present management of these injuries. This is particularly true of hemothorax and its management, and of the syndrome which we know as the "wet lung" syndrome

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Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

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produced now less frequently by battle injury but no less dramatically by automobile injury.

The portion of the book covering complications of wounds of the chest is excellent. In detail, it spells out the requirements for success in the management of such different problems as tension pneumothorax, gastric dilitations, mediastinal emphysema, lung abscess, bronchopleural fistula, and retained foreign bodies in the cardiovascular system. The simplicity of discussion and illustration clarifies a sometimes confused group of problems and makes their consideration a pleasant task.

The third part deals with the management of long-term consequences of thoraco-abdominal wounds. The concepts governing the treatment of organizing hemothorax, draining sinuses of the chest wall, persistent lung abscess, retained foreign bodies, and other problems are clearly presented and have a particular bearing on the treatment and management of traumatically incurred wounds occurring now.

This book is clearly an addition and a welcome one to the literature and history of the management of thoracic and related injuries.—Edwin C. Neville, M. D., and James H. Walker, M. D.

SURGERY IN AMERICA—By A. Scott Earle, M. D., W. B. Saunders Company, Philadelphia and London. 1965. Pp. 280. Illustrated. Price: $8.50.

Surgery in America is a series of original essays or accounts of surgical procedures written by surgical pioneers between 1710 and 1922.

The first published account of a surgical operation appeared in the *Boston News-Letter* in 1710. It was in the form of an advertisement published by an appreciative father concerning Dr. Zabdiel Boylston's operation on his daughter for the removal of a bladder stone, and in 1720 another patient placed an advertisement in the *Boston Gazette* describing a breast amputation by the same Doctor Boylston. These were the first published accounts of elective surgical operations performed in the North American Colonies. It is interesting to note that these reports appeared in the form of paid advertising contributed by grateful patients.

The book contains two papers on ovariotomy by Ephraim McDowell which really record the birth of abdominal surgery because he presents a series of cases with a respectable success rate and so encouraged other surgeons to follow his example.

The first published description of the use of ether for surgical anesthesia was recorded by Henry Jacob Bigelow of Massachusetts-General Hospital. John Collins Warren was the operator and some of his original reports are also published in this book.

The book closes with the classic essay by William Stewart Halsted on "The Training of the Surgeon," which was delivered in 1904 at Yale University.

Physicians and especially surgeons interested in the history of surgery on this continent will enjoy the terse, brief, succinct, publications of these pioneers.

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HALLUX VALGUS, ALLIED DEFORMITIES OF THE FOREFOOT AND METATARSALGIA—By H. Kelikian, M. D., Associate Professor, Department of Orthopedic Surgery, Northwestern University Medical School; and Senior Attending Staff of Chicago Wesley Memorial Hospital. W. B. Saunders Company, Philadelphia & London, 1965. pp. 503. Illustrated. Price: $19.50.

In this comprehensive monograph, the author has endeavored to show the complex relationship of hallux valgus and other deformities of the forefoot. Almost innumerable references have been checked and appraised with an attempt to assign priority to certain procedures and clear up some of the confusion about others. In his criticism of some reports, methods and authors, he reports that failure to investigate the literature thoroughly or to give proper credit to others is one justification for this monograph.

Because of lack of agreement as to terms in describing deviations, he has attempted to arrive at a terminology which would permit universal designation of alterations. By relating the functional anatomy of the forefoot to the clinical features, causal relations and structural alterations, his appraisal of the abnormalities found on examination is based on a good foundation.

Although he discusses palliative measures, it appears that he is more enthusiastic about surgical procedures for the treatment of the problems presented. His discussion of the preliminary problems and post operative care is followed by detailed description of

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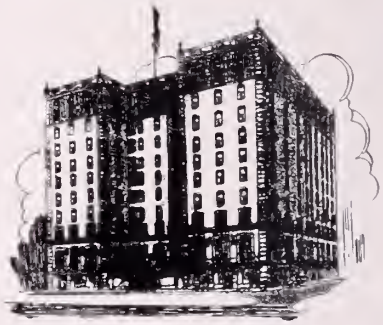

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the many procedures that can be performed for hallux valgus and its associated deformities of the forefoot as well as hallux rigidus, deformities of the toes and the many causes of metatarsalgia. Proximal phalangectomy and surgical syndactylism appear to be favored procedures of the author.

In the last two chapters, Doctor Kelikian discusses surgical complications from the literature as well as those he has observed. He also offers his opinion as to the indications for certain procedures, presents a number of illustrations, and summarizes his previous statements.

This book is an excellent monograph for orthopedic surgeons. Although many personal opinions are expressed, the extensive literature is reviewed and the bibliography is probably the most complete available.—J. C. Pickett, M. D.

* * * *

TRACY'S THE DOCTOR AS A WITNESS—William J. Curran, LL. M., S. M. Hyg., Edward R. Utley Professor of Legal Medicine and Director, Law-Medicine Institute, Boston University. W. B. Saunders Company, Philadelphia and London. 1965. Pp. 196. Price: $5.75.

A summation of facts needed by the physician to guide him in his participation in the legal proceedings of our day. Included are most informative sections on testimony in compensation and malpractice cases. Of particular value is the section "Hints for Specialists and General Practitioners" which specifically points out the special problem of the expert witness. For your convenience each section is followed by a bibliography recommended for further reading.—George R. Callender, Jr., M. D.

Books Received

HANDBOOK OF PHYSICAL MEDICINE and REHABILITATION—By Frank H. Krusen, Professor and Coordinator of Physical Medicine and Rehabilitation, Temple University School of Medicine. W. B. Saunders Company, Philadelphia and London. 1965. Pp. 725. Illustrated. Price: $16.50.

* * * *

CURRENT SURGICAL MANAGEMENT III—By Edwin H. Ellison, M. D., Marquette University School of Medicine; Stanley R. Friesen, M. D., University of Kansas Medical Center and John H. Mulholland, M. D., New York University College of Medicine. W. B. Saunders Company, Philadelphia and London. 1965. Pp. 519. Illustrated. Price: $11.50.

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THE MANAGEMENT OF FRACTURES AND SOFT TISSUE INJURIES—By The Committee on Trauma, American College of Surgeons. W. B. Saunders Company, Philadelphia and London. 1965. Pp. 365. Illustrated. Price: $7.50.

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A SYNOPSIS OF CONTEMPORARY PSYCHIATRY—By George A. Ulett, M. D., Professor and Chairman, Department of Psychiatry at the Missouri Institute of Psychiatry, St. Louis, University of Missouri School of Medicine; and Director, Division of Mental Diseases for the State of Missouri; and D. Wells Goodrich, M. D., Chief, Child Research Branch, National Institute of Mental Health, United States Public Health Service, Bethesda, Maryland. Pp. 299. The C. V. Mosby Company, St. Louis. 1965, Third Edition. Price $6.75.

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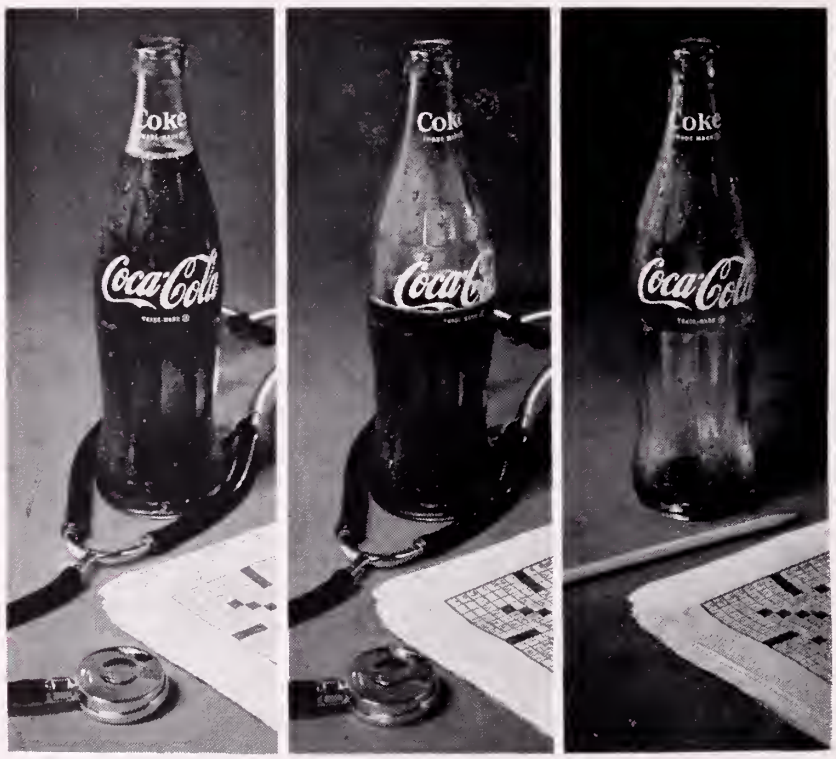
FRACTURE PROBLEMS—By William Hamilton Harris, M. D., Clinical Associate in Orthopedic Surgery, Harvard Medical School; William Norman Jones, M. D., Instructor in Orthopedic Surgery, Harvard Medical School; Otto E. Aufranc, M. D., Assistant Professor of Orthopedic Surgery, Harvard Medical School. C. V. Mosby Company, Saint Louis. 1965. Pp. 371 with illustrations. Price: $20.00.



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The West Virginia Medical Journal

Vol. 61, No. 11 November, 1965

What is Ahead for the Doctor?*

Walter H. Judd, M. D.

It is a great honor and privilege to be invited to speak before this 98th annual convention of the West Virginia State Medical Association. It is always for me a unique personal pleasure to meet with the members of the profession in which I spent 26 years of my life—as a student and as a physician and general surgeon. During those years I enjoyed the deep and abiding satisfactions that always come when a man knows he is being able to bring help to persons in need.

Another reason I treasure the invitation is because of the deep respect I have for this, my own profession. Years of scientific disciplines and daily experience with naked human beings—persons as they really are—have given most doctors habits of thought—cool heads; attitudes of mind—warm hearts; capacity to make decisions—courage; and capacity to carry through—still higher courage. These are precisely the qualities our nation and the world need so desperately in our leaders today and so seldom find.

Formerly, almost the sole reason for doctors to attend conventions like this was to learn about new concepts of disease, new drugs, new instruments, new techniques, including new methods of dealing with old problems, that will enable them to practice their profession more skillfully and more successfully.

But medical meetings have changed—because times have changed. The doctor's job is bigger than was realized. The first fact, not now ahead of us but already upon us, is that with the establishment of Medicare, doctors will no longer be able, individually or collectively, to control the way in which they are to use their skills for the benefit of their patients. A step has been taken by those in political control of this country which is not retraceable. I have no doubt that it will prove to be a disastrous step backward, not a breakthrough forward. But it has been taken.

When a girl comes with a baby born under irregular circumstances, we could say, "Well, you shouldn't have gotten pregnant." But that doesn't accomplish anything. The fact is, she did get pregnant—and we can't put the baby back. Our problem now is how to deal with this Medicare child so as to get from it as much good as possible for our patients, or at least as little harm.

I cannot make any suggestions as to details at this time. We were taught not to prescribe for a patient until we had opportunity to examine him carefully. When the regulations are issued spelling out the precise procedures and conditions under which the mis-labelled Medicare program is to be carried out, each individual physician will have to decide, in the secret places of his own conscience and to some extent in consultation with others whom he trusts, whether he can do more for his patients by participating in the program or by not participating.

I

Perhaps it would be useful at the outset to consider this fateful step as merely the latest in a series of transitions through which our profession has been going in the last century.

Up until 100 years ago, the doctor's main concern was with therapeutics. He did not know too much about actual disease processes, about all he could do was treat symptoms.

The Author

- **Walter H. Judd, M. D., Former Medical Missionary and Congressman for the State of Minnesota.**

*Presented before the opening session of the 98th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 26, 1965.

Then Loeffler discovered the diphtheria bacillus and Koch, the tubercle bacillus. Virchow and others began doing autopsies systematically. It was proved that most symptoms were the result of demonstrable pathological changes in various organs. The doctor began to shift his attention from results to causes, from therapeutics to diagnosis, from symptomatology to etiology. This was the period in which I was trained 40 years ago. It was called the era of therapeutic nihilism. Our professors concentrated so much attention on the disease that it seemed to us they almost forgot the patient.

Then, with better understanding of how most diseases are caused and communicated, a third emphasis naturally developed—preventive medicine. The good doctor had to be an expert not only with the stethoscope and the microscope, but with the immunizing needle.

The incredible discoveries in biochemistry and pharmacology in the last 25 years have made possible such miracles of healing that there has been a renewed emphasis on treatment. Better anesthetics and use of blood and the invention of mechanical devices that are able to carry on during operations the vital functions of various organs have revolutionized surgery.

At the same time, there has been an increasing recognition of the effects of mind and emotions on physiological processes--and vice versa. Too many doctors were losing too many patients to those who paid attention also to people's emotions, and gave them something to have faith in! Psychosomatic medicine belatedly came into its own.

The establishment by the AMA of a Department of Medicine and Religion is another evidence of this broadening of our concerns and concepts. How well can the doctor heal the body if the soul is tormented? And how successful can the clergyman be in healing the soul if the body is tormented? Our patient is more than a physical mechanism with heart, lungs, and liver, needing to be put back in order periodically as a garage mechanic adjusts the carburetor and spark plugs of an automobile. We must deal with the whole person if we would make him whole. He needs not just the doctor or the priest, but both—and together.

As the science of medicine became so massive and so complicated, a steady increase in specialization was inevitable. No man could know it all. Also, the complex and expensive facilities and equipment necessary for proper diagnosis and treatment led with equal inevitability to increasing concentration of physicians in the cities where such facilities were available. How can we preserve and strengthen the general practitioner who is friend and counselor of the whole family as well as physician to each member of it—and available in the neighborhood where the family lives?

Another change has been made necessary by the very success of doctors, scientists and researchers in inventing new cures and perfecting old ones, thereby dramatically increasing life expectancy. People on the average have 21 years more to live than at the beginning of this century. There is no place for these years to be added except at the end of life. Even if the elderly are able to work, where can they get jobs? How are they to support themselves? What are they to do to keep their minds and bodies active and healthy? How can they avoid increasing anxiety as they see the value of their savings, their insurance, their pensions, their Social Security benefits steadily shrinking because their own government has not been willing to discipline itself in order to keep stable the value of the dollars on which they were properly counting to live in deserved security and serenity during their declining years?

They may have fewer illnesses, but longer ones. Much of medical practice has shifted from the infections of pediatrics to the degenerative diseases of geriatrics.

All these changes in practice have led to drastic changes in the economics of medicine. How can the individual patient who needs examination and care by perhaps half a dozen specialists pay for them all? One approach has been expansion of group practice with one fee for all members of the medical team.

While physician's fees have gone up only 100 per cent in the last 25 years, as compared with an overall increase in the cost of living of 115 per cent and an increase in hospital costs of over 400 per cent, the increase in total costs of health services is great and has to be met. How? Most people have done it by the old-fashioned methods of self-reliance and thrift. They save systematically or buy insurance to help with their medical expenses, just as they plan for the purchase of a home or an automobile.

Most accept the fact that rates must be higher for their health insurance, just as rates are higher for their automobile insurance. They pay the increased rates for car insurance without attacks upon the insurance company, or demands that the government pay the premiums. But many expect someone else to help with their health

insurance. They are better conditioned to prepare in advance for calamities that may happen to their automobile bodies than they are for calamities that are certain to happen to their own bodies.

It must be admitted that our government itself, and those desiring to ingratiate themselves with the people in order to get their votes, have encouraged this trend. During the depression of the thirties, the hot war of the forties, the cold war of the fifties, and the seductions of the sixties, the Federal Government has steadily expanded its activities until it now reaches into everybody's life and everybody's pocketbook almost every hour of every day. And the majority elected to Congress last year has now voted to start what will prove to be the most fundamental change in medical care for the American people in the history of our nation. How and under what circumstances you are to practice, what you will be able to earn, how much of what you can earn you will be permitted to keep, and how much what you are permitted to keep will buy, i.e., the value of our currency—all these will depend more than ever before on what happens in Washington.

So the current stage at which we have arrived in this gradual metamorphosis of our profession is that physicians today face steadily increasing governmental intervention in the practice of medicine; and, since the trend cannot be reversed in any foreseeable future, doctors must play a more active role in seeking to guide such intervention as cannot be stopped, into channels that will be least dangerous and damaging to all concerned.

II

Doctors must play a more active role in public affairs for at least three reasons:

First, to insure our future as professional men and women, to safeguard the conditions under which we can use to best advantage the knowledge of disease and skills in helping the sick which we have worked so long and hard to acquire.

Secondly, in order to work toward betterment of environmental conditions that affect adversely our patients. The patient who comes with a stubborn arthritis or ulcer or hypertension or dermatitis frequently has something else wrong with him too. Perhaps he has a boy in Vietnam; or his business is in difficulty; or inflation has eaten up more than half of his life savings; or he is apprehensive about nuclear war. He knows his country is in trouble. He has deep anxieties. If we are really to help him with his whole medical problem, we have to pay more attention to the impact on him of his world environment, and try to influence that environment in the direction of making it more favorable to his well-being. We are not doing our duty as physicians to our patients unless we make maximum effort in this field.

Thirdly, we must play a larger role in public affairs in order to insure our future as human beings. Before any of us are doctors, we are, like businessmen or lawyers, citizens of this Republic. We are trustees of a great and noble heritage of freedom, a political and economic order which made it possible for even those of us who came from humblest circumstances to get the expensive education we could scarcely have dreamed of in most parts of the world. That heritage of freedom is greatly endangered both by determined assault from without and by ignorance, apathy and indifference within.

What we know as doctors about the practice of medicine should and must influence our thinking and activities as citizens. But our obligations as citizens must also influence our thinking and conduct as doctors.

We talk much about what effect our government's action may have upon us. We must give more thought to what effect we can and must have on our government.

III

The public has been taught to believe by those more active in public affairs than we that socialized medicine will give more and better medical care at less cost. Doctors have opposed it because they are sure it will give less and poorer medical care at greater cost.

They know, for one thing, that they will be so busy taking care of those who need their care least but demand it anyway "because Social Security will pay the bill," that the doctors will not be able to give proper time and care to those patients who need them most.

We in the healing profession have concentrated on improving the quality of medical care; those who don't understand what is essential for really good care take high quality for granted and concentrate their attention on trying to get more equitable distribution. They don't realize —yet—that a main result of the supposedly better distribution, *when achieved by government compulsion*, is deterioration of quality. It is the patients who will suffer most, not the doctors.

Yet many people have been led to believe that doctors oppose government-managed and

financed medicine because we think it would hurt *us*. They regard our medical societies as closed-shop unions that want to have complete control of health services in order to promote our own selfish interests. We have failed to show the public that our opposition is due to the conviction, not that it would hurt us, but that it would hurt the public.

It seems impossible for some in our country today to believe that there still are professional people motivated more by concern for those whom they serve than for themselves. Yet witness the way doctors have worked to eliminate or reduce the incidence of diseases which it is their livelihood to treat. The main beneficiaries of their spectacular successes are not the doctors; the beneficiaries are the patients—at the expense of the doctors!

When has any profession ever worked so hard to reduce its own income by making itself less and less necessary? And for their reward, the doctors suffer scurrilous misrepresentations by some of the very people whose lives their efforts are prolonging.

So it is not because we are doctors that we have opposed Medicare; it is because of what we know as doctors about the practice of medicine—the conditions that are essential if patients are to have first class medical care.

But it was not enough for us to be right. We failed somehow to tell and sell our case to the public and the politicians as convincingly as did those on the other side.

Now that the fateful step has been taken, it is unrealistic to think it can be reversed. It takes just over half of the votes in Congress to start such a government program; it takes a two-to-one vote to stop it—because it has to be done over the President's veto. Furthermore, when the government takes people's own money from them under a contract to return at least part of it as so-called benefits, it cannot refuse to carry out that obligation.

Of course, all these billions of dollars cannot be passed out without helping a great many people. But the Medicare program will not really solve the medical problems of our older citizens. It will not provide adequate care for those who need help, principally because so much of the financial assistance will go to those who don't need it, that there won't be enough for those who do need it.

Besides, more and more resentment will develop as people come to realize that it gives no assistance to those in our population who often need help more than most of the elderly. It is cruel to ask breadwinners in their thirties, trying to support their families in decency and with far greater medical and other bills than most retired people have, to pay larger and larger portions of their earnings to take care of others, without for decades any assistance with their own medical expenses. One cannot blame them for resenting what amounts to class legislation—aid to only those over 65. Just what is the justification for discrimination on the basis of age? If it is wrong to discriminate against some citizens on the basis of their race, creed, color, or national origin—and it is—what makes it right to discriminate against other citizens, those below 65, on the basis of their age? Not *need,* mind you; a good society must always find ways to provide for those in need. But Medicare pays no attention to need, only age.

What most doctors would like to support, I think, are programs, private and public, that would give:

1. Proper medical assistance to *all* who need it;
2. *All* the assistance they need;
3. Financed by a tax on *all* citizens; and
4. A tax on *all* their income—not just on the earnings of those who work.

Medicare is grossly unfair in both its benefits and its burden. It simply does not do what is needed.

IV

During the honeymoon while the public, and especially the grievously misled elder people, are discovering that Medicare is not a sound answer to the problem, one of the tasks ahead of doctors is to lead in trying to get solutions that are sound. First and most basic is the need for a change in attitude toward retirement on the part of the public at large and of retired persons themselves.

For ten years I lived and practiced in China and came to admire the sensibleness and helpfulness of the attitudes toward age that the Chinese had developed during the centuries. Instead of dreading the day of retirement, a Chinese looked forward to it with eagerness. He knew that it would be not the end, but the beginning of the period of greatest usefulness in his life. The Chinese people had learned that the truly great human resource is neither brawn nor brains; it is wisdom. And wisdom comes only with age and long years of experience.

Instead of being cast aside as has-beens or as burdens to be borne out of love or charity, the Chinese person knew that on retirement he

would be economically secure because he could be certain his sons or nephews or cousins would provide for him, just as he had worked during all his active years to support his elders; he would enjoy great respect from all; he would have importance and prestige, yes, and power, because of the wisdom he had acquired and the counsel he would be permitted and expected to provide for his family and his community.

As long as our American pattern is continued of regarding retired persons as a kind of liability rather than as one of our richest assets to be utilized to the full, we will continue to have retirees thrust into depression when the community and nation to which they have given their whole lives seem no longer to need them. One of the most devastating things that can happen to a human personality is a sense of uselessness or of not being needed. No wonder so many millions of hospital and nursing home days are consumed by such persons whose main affliction understandably is melancholia.

Our society has concentrated on preparation of youth for adulthood; but how much real thought has been given to preparation for retirement? The qualities of self-reliance, industry, maximum effort-to-achieve which from childhood to 65 have been the chief virtues, suddenly become vices. How can there be such a sudden reversal of all the habit patterns of a lifetime without emotional tension and strain, even disorientation?

Since it is doctors who gave people these extra 21 years of life, doctors should lead in probing for answers. Think of the brainpower and millions of dollars that are put into finding the answer to some relatively rare medical problem. There should be coordinated and massive attacks upon the whole problem of how to enable the aged to live well and satisfyingly—by doctors, associations of employers and of employees—the unions, by universities, foundations, social scientists, ministers, all who are competent and who care. Doctors can pioneer in doing basic thinking and exploring in efforts to solve these problems that affect more people today than do even cancer and cardiovascular diseases.

Another urgent need is to remove the discriminatory legislation that prevents older people from earning all they can, and instead penalizes them if they earn more than $1,500 a year. Some of us have tried for a decade to get this cruel and arbitrary limitation on earnings eliminated. The objection is always made that if those over 65 who earn more than the limit allowed were permitted to draw their Social Security benefits, it would cost the Treasury up to two billion dollars more a year. Well, Medicare will cost it a great deal more, and be less beneficial in the end. If the health needs of the elderly are as serious as portrayed, then let us take this step so necessary to the meeting of those health needs. The two billion dollars a year will be a small price to pay, and there are plenty of other places where it can be saved by discontinuing various boon-doggling programs—with benefit to all concerned.

Another proper place for government aid is in financing more rapid construction of more nursing homes that can furnish the care most older people need at so much less cost than can hospitals—and without crowding out of the hospitals those who must have what only hospitals can provide. There is a world of difference between the Hill-Burton pattern of non-recurring grants on a matching basis for construction of facilities and provision of equipment, and annually recurring subsidies for operation of those facilities. With the first goes no continuing control, as has been proved in construction of hospitals, college laboratories, airports. The institutions are then able to use their own funds for the operation and management of the facilities. This is a sound way for government to help states, cities and communities.

The medical profession should also persist in efforts to get all states to implement fully the Kerr-Mills type of program so that every retiree can know that he will never be without good medical care because of inability to pay, that when the limited benefits under the Medicare program have been exhausted, he will never be left destitute. Such assurance will do more to relieve the anxiety that leads to depression, melancholia, and higher medical costs than almost any other single factor.

V

Finally, may I suggest one other task that is ahead. It involves an even broader area in which doctors must become more active. Government itself is changing—in response to the pressure of those who want it to adopt a quite different philosophy from that on which our nation was founded.

For what main purpose did our forefathers originally come to this country? To establish a government that would look after them? No, they came here to get a chance to look after themselves. The system they set up worked. But it is under determined challenge today, and it is losing ground.

In essence, the struggle both here and all around the world, is between two philosophies of government—between those who believe in government-from-the-top-down and those who believe in government-from-the-bottom-up.

Confronted with a tough problem, one group goes to the central government *first;* the other goes to the central government *last*—that is, only if and when their own efforts and all local remedies have been exhausted.

One believes that because some Federal Government is necessary, *more* government must be better. The other remembers that the history of man's struggle for liberty is the history of his struggle to hold down, not expand, the powers of government.

One believes that speed in solving a problem is in direct proportion to the amount of money the Federal Government puts into it (which of course it can only do with money it has taken from you, there is no other source). Others believe that almost always a more serious bottleneck than lack of funds is lack of trained and dedicated personnel. Motivation of men is more crucial than money.

One believes that because a national government must and should intervene in emergencies —wars, earthquakes, floods, depressions, civil disorders; therefore it should take over more and more management of people's lives when there are no such emergencies.

One believes that government should provide equal *rewards* to its citizens; the other believes the main function of a good government is to provide equal *opportunities* for its citizens—not because it does not want the fullest possible rewards for all, but just because it does want such rewards, and believes this is the best way to get them.

Some because of their preoccupation with those who are inadequate or unfortunate—and there will always be such—become so concerned with helping these that they think this is the first, if not almost the sole function of a good society. Others believe that the *primary* effort of a good government must be provision of maximum opportunity and incentive for the many to become solvent—for only as the many become solvent and self-supporting can there long be anything with which to help the unfortunate.

In summary, what kind of society is best? One which does most for people directly? Or one which makes it possible for most people to do most for themselves, and then assists with those who for whatever reason cannot or do not provide properly for themselves and their families?

These larger issues are decided in the political arena, and nowhere else. It is hard to justify any physician's thinking he is too busy to work at government—which means politics. All our scientific attainments, and all our knowledge of medicine, and all the money the AMA spent for public relations men and lobbyists these last years did not succeed in preventing Medicare. While we can be exceedingly proud of the magnificent political efforts made by a great many doctors in the last few years, by and large we were too little and too late, and we were too inexperienced in the tactics and techniques of mobilizing and exercising political power.

So, if there is to be the best possible medical care for all the American people, doctors must expand their influence in public affairs. To do that, they must participate in politics. For politics determines government—and government today determines the conditions of our lives, as well as of our practice.

Therefore, join the political party you think is nearest right on the most important issues, work in and through it to help select, and then to help elect, good men and women to public office at every level of government. It is votes at elections, more than letters after elections, that decide what Congress does.

Don't imagine you can do much to change the votes of a Congressman who owes his election to those who oppose your views. Your job is to elect persons who already hold the same general views as you. They will want to vote for them out of conviction, and with your support they can do so without committing political suicide, something not too many in any field like to do.

Some have said that Congress has surrendered to the pressures and skill of the President. No, the Congress was changed at the polls last fall. The majority is now controlled by the labor forces that elected it.

One more requirement! More doctors must become willing to be candidates for public office. That's tough, I can testify. But both patriotism and good sense require that all citizens, no matter how specialized their training, be willing to sacrifice their careers to go into public life as a public service, just as you were called once, and as your sons are being called now, to sacrifice their careers to go into the armed forces as a public service.

Only as we do these things—not just discuss them, but act—will there be hope. The most

wonderful thing about our country, the thing which we must strive to preserve at all cost, is the privilege we still have of changing the things we think are wrong. Thank God our system is such that wherever conditions are bad, or don't meet our standards, we *can* correct them —if we will work in politics.

Please don't think I am trying to lecture you today. Rather, I am appealing to you for help. This patient is too sick to be saved without the intelligent and dedicated effort of all alert citizens. It particularly needs the leadership of men and women who have the qualities of mind and heart of the good physician—the cool head, the warm heart, the capacity to decide, and the courage to carry through.

Who is so well equipped to influence the attitudes and actions of our people as are you—in your dual role as doctors and citizens? Freedom is worth it.

Why Get Vaccinated Against Smallpox?

RECENTLY, a verified case of smallpox occurred in the United States, the first in many years. This scourge once killed thousands of Americans every year, but is now long gone from this country. It is, however, by no means gone from the world even though an effective vaccine has been available for a long time. In this era of air travel, someone infected with smallpox may come to this country and infect many others, even before doctors are aware that the disease is back again. Although health authorities require vaccination certificates of all persons entering this country, returning citizens and foreigners alike, a slip-up is always possible. Several smallpox scares have in recent years been precipitated by travelers. The one case this summer was brought in by a traveler from Africa.

In a recent release on health and safety tips the American Medical Association disclosed that, once vaccinated, only a relatively few of the American public keep up the booster schedule which requires boosters every three to five years to maintain protection against smallpox. The level of immunity against the disease in the United States has been shrinking steadily for years, as more and more people neglect to get boosters. Health authorities estimate that at least three-fourths of the population is inadequately protected. The World Health Organization is spurring a concerted drive all over the world in 1965 on behalf of smallpox vaccinations. The disease is increasing in some areas of Asia and in other lands. In the United States today the risk of contractng smallpox is admittedly slight, but it is also needless. Vaccination will eliminate this risk entirely.—Journal of the Florida Medical Association.

Methods in the Care of the Fracture Patient*

Milton C. Cobey, M. D.

It is not the purpose of this paper to give you a course in the management of fractures but to call your attention to the fact that each of us, regardless of his medical specialty, is first of all a physician. Each has had basic training in the treatment of fractures and we must see that this knowledge, enabling us, as it does, to carry out our responsibility to the public is most important. Even with our present day divided highways, safety belts, breakaway steering wheels, self-locking doors and improved highway engineering, the National Safety Council expects an increase of 40 per cent in automobile accidents in the next six years and a 72 per cent increase in all types of accidents, automobile or other, in the next ten years. The Council's expectations are based on the rapid increase in population and on the increased close proximity of people to each other in today's living. The number of physicians presently available cannot hope to keep up with the increased number of accidents.

Volunteer Ambulance Crews Trained

We of the state and local chapters of the American College of Surgeons, however, have another weapon with which to combat the ever increasing volume of work: the present day efficiency of the hospital emergency room. We are able to train volunteer ambulance crews not only to splint and render excellent emergency care at the scene of the accident but to help in the more definitive care in the emergency room. These ambulance crews are enjoying their privilege of becoming first aid men. They are of great help to the physician in splinting and transporting, and in the rendering of definitive treatment in the individual case. For the time required of us to train these men in groups, their efficiency and the assistance they give us constitute suitable reward.

Instruction Courses in Many Cities

At this very moment, under the supervision of the North Carolina Chapter of the American College of Surgeons, an instruction course is in progress in a city on that state's east coast. Four times a year, in different parts of the state, such a course is taught and the east coast city is one of many in which this is being done.

At Maryland's Johns Hopkins and City Hospitals in Baltimore, people from the Eastern Shore, also from Southern Maryland and Western Maryland, enroll at one or the other of the two hospitals for the two-day course in the care of the injured patient.

Throughout Maryland and North Carolina and in many other states, including Ohio, the ambulance men take turns working in the emergency room.

The National Safety Council's awareness and appreciation of the part played by the American College of Surgeons in the care of the injured, the training of personnel and from an advisory aspect as to protection against home and highway accidents are made manifest by the fact that of the four physicians on this forty-member council, one is a Fellow of the College. The first aid men are taught to apply a Thomas splint for traction, highway emergency traction for fractures of the lower extremities, application of arm splints for fractures of the upper extremities and the use of the prone stretcher technique for fractures and injuries of the spine. We teach that sucking chest wounds are to be sealed at the place of accident, that head injuries are to be temporarily bandaged to staunch bleeding and that the patient be kept flat and transported to the hospital. We also teach the more important factor that these people must be gotten to the hospital properly splinted which means that the ambulance is driven at proper speed and with proper care in handling so as to avoid the risk of further injury as a result of an additional accident as well as that which might be sustained when the ambulance is driven rapidly and swung around corners, throwing the patient into shock.

The Author

- **Milton C. Cobey, M. D., Clinical Professor of Orthopedic Surgery, Georgetown University School of Medicine, Washington, D. C.**

*Presented before the annual meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier in White Sulphur Springs, April 29-May 1, 1965.

Submitted to the Publication Committee, May 5, 1965.

First aid men are enthusiasts, else they would not be there helping us for nothing in their spare time but their enthusiasm in so far as it applies to operation of the ambulance must be controlled for the safety of all concerned.

Again, the common fracture is taken care of in the emergency room, with application of the principles learned both in war and in peace. For example, care of the patient as a whole comes first. A multiple injury patient with fractures is considered as a whole. In other words, the fractures are splinted and then the abdominal or head or chest injury is looked into and cared for by the properly trained physician and his team. The physician taking care of the fracture is a member of the team that takes care of the patient as a whole and his importance is enhanced by the training he has given his first aid men in the care and transportation of the patient with the common fracture.

Closed Reduction Always Preferable

It is our job not to overtreat fractures. We know that if the break in the tibia, for example, is not an open fracture, healing time will be reduced if open surgery and internal fixation can be avoided and adequate reduction and maintenance of the bone ends in good external fixation still be obtained. We know that open fractures are best treated by immediate cleansing, with debridement and closure of the open wound either by sutures in the operating room or vaseline dressings in the operating room, adequate reduction of the fracture itself, external fixation such as plaster of paris, and avoidance of the use of metal. Good reduction and good fixation without open reduction whenever possible, is to be desired in any fracture case since secondary infection from operative interference is a disaster, and one that occurs only too often.

A plea, then, is made for good fixation of the fracture by the first aid man at the site of the accident and another is made for adequate transportation of the patient with the least injury to him and without risk to the safety of others on the highway. Next, a plea is made for teamwork with all emergency room personnel so that the patient is adequately cared for and his general condition enhanced, not hindered, by his sojourn in the emergency room. To achieve these ends, a well organized and efficiently operating emergency room is necessary. Such has been the nationwide goal of the College of Surgeons through the Committee of Doctor Kennedy. Finally, a plea is made that the team of physicians and nurses, in caring for the injured patient in the operating room, do so in the simplest, most direct manner to bring about as rapid healing of the fracture as possible. Too much metal is used and too much internal fixation resorted to in fracture cases, often to the detriment of the patient and with a resultant increase in morbidity.

'Hot Line' for Drug Reactions

No responsible person can quarrel with the vast communications network set up throughout the world to exchange information on the side effects of drugs. But this necessarily imposes the obligation on observers to be reasonably certain there is a fire before pulling this world-wide alarm system. A drug's side effects should be measured against the good it does, else the benefits of therapeutic advances are nullified. Let us remember that illness itself creates adverse manifestations, sometimes unexpected and bizarre. To assume that all of the patient's complaints and distress are due to an administered drug can be the worst kind of *post hoc, ergo propter hoc* reasoning, serving only to damage the good name of a drug and perhaps cause its withdrawal.—Theodore G. Klumpp, M.D., in Massachusetts Physician.

Special Article

Depression in the Aged

David H. Smith, M. D.

This paper presents a report on six elderly patients, all between the ages of 70 and 80. Two were males and four were females. All six were suffering from a depressive reaction. They were given from six to eight electric shock treatments, also treatment by psychotherapy. Five of the patients had excellent results.

Depression is a diagnosis often missed in all age groups, but more frequently in the sixty-five-and-over group. The probable reason for this is that it often is confused with senile deterioration or cerebral arteriosclerosis. It is a difficult differential diagnosis. The depressed patient often appears to have memory loss, confusion and other symptoms that could be mistaken for senility associated with cerebral arteriosclerosis.

In eliciting the history, it is most important to persist in one's attempts to determine whether the patient cannot remember or whether he just does not care enough to remember. Is the apparent confusion due to organic brain disease or to lack of concentration in a depressed state? Oftentimes the history from the family is extremely important in establishing the diagnosis. The family may say that the patient has seemed to lose interest, doesn't care to talk and has not been interested in food. In senile deterioration, the history usually is not one of loss of interest but, rather, is that of a "one-track" interest, or of many interests, the patient being unable to center on any one. Also, the senile person usually has an increased flow of words, although of a rambling and retrospective nature. The depressed patient often has a history of being much better in the latter part of the day. The senile patient, as a rule, shows no fixed pattern but more often will mix days and nights up, sleeping during the day and wandering about during the night.

Two illustrative case reports are presented. The patient in one case was a 78-year-old married female who was seen in consultation at the Ohio Valley General Hospital in Wheeling. Presenting symptoms were loss of weight, constipation, pain in lower abdomen and flatulence.

Submitted to the Publication Committee, May 14, 1965.

The Author

- **David H. Smith, M. D., Department of Psychiatry, The Wheeling Clinic, Wheeling, W. Va.**

Physical examination was essentially negative. X-rays of the stomach and gastrointestinal tract were negative. The nurses' notes indicated that the patient ate poorly and seemed to have little interest in her surroundings. She was referred for psychiatric consultation.

Psychiatric examination showed a thin, weak-looking woman with an expressionless face. When the psychiatrist went up to her bed, she did not acknowledge his presence vocally nor with any movement of her body. She stared straight ahead. When spoken to, she answered slowly in a low voice. Psychomotor retardation was present. When asked when she was born, she gave the wrong date. On insisting that she concentrate, she gave the right one. She obviously was not interested in the questions. Although cerebration was slow, her memory proved to be good and there was no confusion. She seemed to be depressed, with not too much in the way of senile changes. The family stated that she had been gradually losing interest. She had reached the point at which she would not bother with the newspaper, did not want to see relatives or friends. She spent most of her time sitting and had to be told to eat or to go to bed. Often when spoken to, she would give no indication that she heard the question, but would answer after being asked the same question several times. Members of the family were adamant in their opinion that she was not mentally ill but just "getting old."

This patient was started on electric shock treatment, six treatments being given over a two-week period. They produced a mild memory impairment and slight confusion but response otherwise was good. She became much more alert, more interested, and her appetite improved.

On a follow-up visit two weeks after the last electric shock treatment, she was better than she had been when she was discharged. She remarked that she felt better than she had in years. Obviously, the depression had been slowly deepening, with the patient being unaware of it, and with her family thinking that she was suffering from progressive "hardening of the arteries."

When seen a year after discharge, she still was in good remission with, surprisingly, very few senile changes mentally.

The second case was that of a 71-year-old white widowed female. She lived with her spinster daughter. She was admitted because of pain in the lower abdomen, rectal bleeding and loss of weight.

Physical examination showed a frail, weak-looking woman. No signs of organic disease were found, except that she appeared undernourished. A gastrointestinal series, barium enema and sigmoidoscopic examination were negative except for external hemorrhoids. Routine laboratory work showed mild hypochromic anemia. Protein bound iodine was 4.8. Chest x-ray was negative. Neurological examination was negative.

It was noted by the nurses that the patient lay in bed most of the time. She did not read nor watch television. She did not express interest in anything. Her appetite was poor. She was given an enema, with resultant hard stool. She was friendly when spoken to but seldom initiated a conversation with the nurses or visitors. She would at times lie on her side with her face to the wall, presumably to avoid social contact with nurses and others who came into her room.

Psychiatric examination showed the patient to be coherent and relevant. Her memory was good for recent and remote events. There was no evidence of any psychotic ideation nor of disturbance of the thought processes. There was no confusion. The patient said she felt that she had some incurable disease, probably cancer, and was going to die. She said dying would be a great relief as life was a burden to her.

During the interview, a great deal of time was spent on the subject of death. Interestingly enough, the patient actually became animated and cheerful when death was discussed. It is the author's opinion that the reason for this was that it was the first time anyone had discussed death with her openly. In the second place, death is a "solution" in some ways. At least the patient thought of it in this manner.

There was a history of gradual loss of interest. The patient said that many of her friends had died or moved away. She said she was tired of meeting and talking to her relatives and other people who did not understand her, mouthing the same old platitudes such as "You are looking good" and "There is no reason for you to be sick." She said she was very tired. Everything was an effort. "The only place I am reasonably content is in bed. I hate to get out of bed in the morning, and I cannot get back in bed soon enough at night."

This patient had five electric shock treatments —two bilateral and three unilateral. There were no complications. She showed good improvement. Follow-up care showed that she had gained weight and had regained interest. She engaged in social and church activities. A year and a half after discharge, she still was doing well. She has been taking Librium 5 mg. three times a day, every 8 hours, and Elavil 10 mg. three times a day, every 8 hours since leaving the hospital.

The second case illustrates the feelings and the attitude of many older persons. Certainly in their cases, death might be presumed to be more imminent. Their friends are dying and they are aging. They do want to talk about death. Yet, if they mention it to their families, a deluge of protests and denials follows. "You are not going to die!" "Don't be so foolish!" "Why do you have to be so morbid?" Frequently the doctor will make the same error. The patient often is left to face the reality of death alone, whereas a frank talk can be comforting. Often the thought of death can be frightening to them even though they are tired and see no point in living.

When they can talk to someone who shows no fear and who encourages them to face the reality of life, old age and death and is willing to talk about all of these aspects, they are relieved.

After the depression is relieved by electric shock treatment, this type of ventilation is important, as is supportive psychotherapy. Electric shock therapy relieves the depression but psychotherapy helps prevent relapses. In fact, if the depression is not too deep, psychotherapy and drugs may suffice to bring about a remission without the necessity of resorting to electric shock therapy. The important basic step is recognition of the depression.

These elderly patients were given a maximum of eight electric shock treatments. The first two were given bilaterally, the next four to six unilaterally. The method has been found to reduce

confusion and memory loss, an extremely important factor in an older person who probably has suffered some deterioration and whose mental reserves are low.

The electric shock treatment is given after intravenous administration of Anectine and sodium brevitol. The risk is minimal even if there is some degree of hypertension or arteriosclerotic heart disease, or both. In fact, there are few physical contraindications to electric shock treatment.

Summary

Depression in the aged often is overlooked or misdiagnosed as senility or a chronic brain syndrome associated with cerebral arteriosclerosis. When diagnosed and the patient treated with electric shock therapy and psychotherapy, the results often are very good. Electric shock treatment is tolerated well by persons in the age group seventy to eighty.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Special Article

Medical Education—A Continuum*

Edward W. Dempsey, Ph. D.

I am very grateful for the opportunity to speak to you tonight. As one who has spent most of his professional life in medical education, I share with your teachers the pride and pleasure we all feel at this moment of your graduation. To us—if I may join with your faculty for the moment—you have justified our faith and have fulfilled our hopes. To you, a stage has been reached to signal important new opportunities and responsibilities which are now yours.

As graduates, you have attained a degree in your professional development; you have climbed a rung on the ladder of your personal achievement; you have increased your intellectual volume by a mark on the graduated cylinder which measures it. You have reached a stage, but not an end-point. You have before you challenging and exciting opportunities. But you still have much to learn. Medical knowledge is increasing at a rapid rate; your attainment of professional qualifications does not mark the end of your scholarship but only a change in that your future studies must be pursued more independently.

There are many current signs to indicate that medical practice will experience a series of future upheavais. Increasing concerns over the rising costs of patient care are forcing hospitals to search for more efficient procedures. Duplication of expensive equipment will become increasingly difficult. Modern transportation makes centralized facilities available over great distances and permits formerly unaccessible regions to be reached. Telecommunication now permits a doctor in Boston to examine a patient in San Francisco.

We, none of us, know what tomorrow may bring; but we can be pretty sure it will be different.

A Long and Rich History

Medicine has a long and rich history. Originating in mythology, permeated by witchcraft and demonology, a slow increment of fact founded on direct observation gradually replaced the mystical content and authoritarian attitudes of the ancients. Medicine's effectiveness has increased in direct ratio to its scientific content. And the headlong pace by which new information is now being pursued shows no signs of abating. It follows that medicine tomorrow will be far more effective than today.

It also follows that medicine in the future will be far more complex than it is today. This conclusion, its consequences, and its impact on you —these are the principal subjects I would like to discuss with you tonight.

Medicine developed slowly in the United States until the turn of the century. With the establishment of the four-year curriculum at Hopkins and Harvard, and with the revolution in medical education which followed the Flexner report, a faster tempo became evident. However, the practice of medicine was not greatly altered. Solo, general practice was the rule; specialists were rare and located only in the large medical centers. Formal specialty training programs were at first practically non-existent. Beginning with Halsted's assistants at the Johns Hopkins Hospital, a pattern of post-doctoral training began to emerge. By the late 1930's, residency programs existed in many hospitals, especially in those affiliated with medical schools.

Post-Doctoral Medical Education

At the close of World War II, the phenomenon of post-doctoral medical education virtually exploded on the scene. Young physicians returning

The Author

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*Presented before the Pre-Commencement Exercises at the West Virginia University School of Medicine, May 30, 1965. Submitted to the Publication Committee, June 15, 1965.

from military service had noticed the demonstrably successful care provided by specialists. These returning veterans besieged medical schools and teaching hospitals, demanding specialty training, the value of which they so keenly appreciated. In 1941, there were approximately 5,000 residencies and 8,000 internships available in the United States. By contrast, in 1961 there were openings for 12,000 interns and 35,000 residents. The demand for specialty training is such that over ten per cent of all physicians are now in house-staff positions.

Eight out of every ten of you receiving the M.D. degree this year will seek training as a specialist. In recent years, undergraduate medical education has been shifted to a minority position. Whereas a physician has spent four years in medical school, he will spend, on the average, four and one-half years in internship, residency and fellowship training. Also, while the nation's 87 medical schools enrolled 32,000 undergraduate medical school students in 1964, there were over 39,000 physicians enrolled in internships and residencies.

From all of this, one must conclude that undergraduate medical education no longer produces a finished physician. Graduation is an interlude, marking a transition to further study. Medical education has become a continuum which will last as long as you live.

The exponential growth of scientific knowledge will require each of you to continue his education if you are to circumvent professional obsolescence. It is rapidly becoming a truism that continuation education, or perhaps it would be better to say a continuum of education, is the road to professional survival. If the experience of the past is any guide, each of you must learn faster in the future than in the past, no matter how swift that learning may have seemed. The magnitude and rate of change cannot be overemphasized. Approximately one-quarter of the physicians in the United States today graduated from the nation's medical schools during the last ten years. The remaining three-quarters completed their medical training prior to the discovery or development of a vast array of currently used drugs, diagnostic techniques, therapeutic regimens, and operative procedures.

Can Specialists Provide Comprehensive Care?

The vastly increased body of medical knowledge available today has compelled physicians to become specialists. But how, you may ask, can specialists provide comprehensive care? Much can be said on this topic; I would only like to say now that as specialists have increased in number, so have group practice arrangements. Moreover, in many specialties expensive, cumbersome, and complicated devices are required, such as those for high voltage x-irradiation and open-heart surgery. Modern diagnostic and therapeutic procedures require laboratory determinations unheard of a decade ago. Such changes in medical procedures lead to increased hospitalization of patients and increased dependence by the physician upon hospital or other centralized services. But such changes also lead to better patient care and to the saving of many lives.

As better care has become possible, people have become increasingly aware of what should be available, and the level of public expectation has risen. The space in newspapers and the time on radio and television attest to the interest the public has in medical affairs. The Appalachia program and Medicare, and the bill to create Medical Complexes to combat heart disease, cancer and stroke—all these illustrate the public's awareness of the need to make new medical procedures more widely available than they have been formerly. The Administration and Congress are simply responding to a rising level of public expectation.

The Physician in the Future

The physicians who graduated 30 years ago could hardly have anticipated how their lives were soon to be changed by the advent of antibiotics, of regulation of electrolytes, of psychodynamic drugs, or improvements in vascular surgery—to mention only a few past achievements in medicine. Yet, they had to live in a world in which these events occurred. They had to master new procedures or become obsolescent. They had to continue their education.

You, today, can hardly anticipate the impact of discoveries yet to be made. Replacement of failing organs by natural or artificial substitutes is certainly possible. Several leads point toward steady reduction, or even abolition, of various forms of cancer. Research on hypertension, and on atherosclerosis, indicates that these diseases need not forever be unconquerable. Heart disease, cancer and stroke are the three greatest killers, followed by accidents. Is it possible that more and more you will become traumatic surgeons? Or that the regulation of metabolic errors caused by genetic aberrations will become commonplace? Such a re-ordering of emphasis would be no greater than that which happened when antibiotics so drastically curtailed infectious diseases.

Tonight you are launched upon your career. It will not be easy, but it will be satisfying. It will be filled with uncertainty, but it will be

stimulating. It will require continuous work and study, but you are equipped as no one before has ever been to meet the demands that will be made of you. The disturbances and difficulties which you will experience will be counterbalanced by benefits to the health and pleasure of your patients.

You have joined a great profession. I am sure its greatness will be enhanced by your presence.

I salute you. Godspeed.

The Magic of a Name

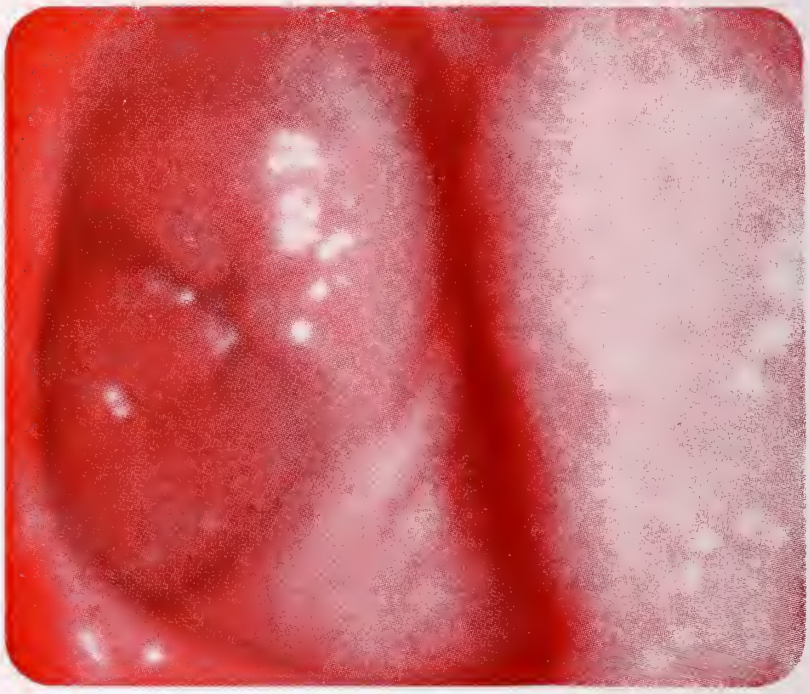
There may be at least nine different kinds of names for drugs. There is the chemical name, which identifies it absolutely; it tells us what is in the molecule and how the elements are arranged. The chemical name is far too unwieldy to be used verbally and even, excepting in chemical literature, in medical writing. So a second name, the generic name, came into being; it is simpler, it is a coined name, and is sometimes a shortened form of the chemical name. A third kind is what is called the common name, and is simply the generic name. A fourth name is the trademark name, the name under which a company markets the product as a medicine. A fifth phrase, the trade name, is the trademark name. So is the sixth version, the brand name. A seventh form is the nonproprietary name, which is the generic name. The eighth kind of name is the official name, as it is listed in the U.S.P. And a drug's ninth name is what is known as an official synonym, as aspirin.

The number of drugs increases with time. Each one acquires two names, generic and trademark. Inventing new and pleasing names has become more and more difficult; the problem has even been turned over to computers. But which form shall we use?

For older drugs and alkaloids, as morphine and atropine, there is no problem. But for most newer agents, a decision must be made. There is one argument for generic, and that is price. There is another, probably of less importance, and that is the duplication of trademark names marketed by different companies. But there are three arguments for trademark. In the first place, a company has invested a great deal of money to develop a drug, and wants properly to recover its investment. And the second reason commonly given is that to take advantage of a situation that may or may not exist, by buying drugs at bargain prices, would stifle research. A third argument offered is to the effect that not all chemically identical drugs are identically pure or identically potent. Indeed, when a prescription contains a generic name, it is still incumbent on the pharmacist to dispense a drug he knows to be of the highest quality.

Shall we give our patients the cheapest? Is it through no accident that cheap has come to mean inferior as well as inexpensive? When a reputable and well-known house puts its name on a product, it has added something to it, and what may be its most important element. If we could be sure that our patients could get the same medication and save money while doing it, other arguments might not carry the day. But if there is a difference, then it is well worth it.—F. C., in The Nebraska State Medical Journal.

Intragastric photography studies[1]



A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

B/Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.

Now you can see Pro-Banthīne® at work
(propantheline bromide)

Pro-Banthīne is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthīne over belladonna alkaloids.

Pro-Banthīne produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthīne. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthīne which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Dosage—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily.

Side Effects and Contraindications—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

Research in the Service of Medicine

The President's Page

MEDICARE REPORT

FOLLOWING the extraordinary session of the AMA House of Delegates in Chicago, October 2-3, 1965, your President—interpreting his responsibility to keep the members of the West Virginia State Medical Association informed in matters pertaining to their primary responsibility of providing the highest quality of medical care to their patients, with the least interruption of the all-important patient-doctor relationship, and with the least threat of violation of his moral and ethical principles—feels that this information takes precedence over any other matters that might be presented on the President's Page. Therefore, the highlights of the report received from the AMA will be presented here and I hope that all of our members will take time to read the complete report published in *The AMA News*.

1. Physician-Patient Relationship. Public Law 89-97 affects the legal, traditional, and ethical concepts of the physician-patient relationship. Legal counsel for the American Medical Association has stated that an individual physician acting independently and not in concert with others can lawfully refuse to accept any person as a patient who is a beneficiary under the program, or he may elect to treat such persons.

2. It should be noted that Section 6 of the Principles of Medical Ethics provides that "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause the deterioration of the quality of medical care." If after regulations are promulgated and the Medicare law becomes effective, the individual physician acting independently and not in concert with others, finds it does tend to impair the free and complete exercise of his medical judgment and skill or to cause a deterioration of the quality of medical care, the individual physician would be justified under this Principle in not participating under the law.

3. The American Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

4. Current practices and customary procedures with respect to certification for hospital admission and care shall be continued under Public Law 89-97. The AMA Advisory Committee and the Association representatives to the technical advisory committees are advised to seek to accomplish this objective.

5. In the event of a dispute between physicians and carriers with respect to reasonable, customary, or usual fees, such disputes shall be resolved with the participation of the appropriate local medical society.

6. Hospital utilization review committees shall be composed of practicing physicians.

7. Compensation for Medical Services. Your Reference Committee believes that the physician should be informed fully as to the merits and limitations of billing patients directly for services, or accepting an assignment to enable payment by a federally designated fiscal intermediary, so that the physician can decide for himself in each instance the method of compensation he prefers. We recommend that the Association take appropriate action to inform physicians regarding the options of payment for services available to them under the law and its regulations.

8. Your Reference Committee recommends that the House urge constituent medical societies and physicians to support and assist AMPAC and local medical political action committees in their efforts to elect candidates to office who will help preserve the physician's right to the free and independent practice of medicine.

Seigle W. Parks, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

The Publication Committee deeply regrets the passing of a dutiful and valued member of the Editorial Board. Dr. Charles L. Goodhand was appointed to this Committee by Council in 1961. His knowledge of medicine far surpassed that of his specialty and his instructive comments and criticisms of scientific and special articles were most helpful. His editorials indicated a deep concern for the quality and pattern of medical practice in West Virginia. He did not diminish his responsibilities nor service to *The Journal* during the several years in which he was councilor and officer of the West Virginia State Medical Association, although his executive activities were highly demanding in thought and time.

CHARLES L. GOODHAND, M. D.

Doctor Goodhand clearly foresaw the unfolding changes in the practice of medicine and worked unselfishly to prevent the corrosive inroads of government domination. When the battle was over, he urged all of us to continue to provide the best medical service for our sick and ailing regardless of the objectionable pattern of medical practice set forth by our politicians.

Doctor Goodhand's special theme throughout his executive term was the need for better communication between national, state and county societies. He urged all members to participate in the affairs of medical organization and to

Charles L. Goodhand, M. D.
1906-1965

share actively in all matters pertaining to medical freedom.

All physicians are urged to reread the eight precepts for unselfish devotion to medicine that were published on the President's Page in *The Journal* in January of 1964. The West Virginia State Medical Association and all of us on the Editorial Staff might well be guided by his admonition—"Remember that American Medicine has become great as a result of dedication, free competitive spirit and the pursuit of the goal of excellence."

Dr. Charles L. Goodhand, 58, a Past President of the West Virginia State Medical Association, died on September 10 of a heart attack suffered while attending a medical meeting in Ocean City, Maryland.

Doctor Goodhand, a native of Chester, Maryland, was graduated in 1928 from Western Maryland College and taught high school for two years in Sudlerville, Maryland. He then enrolled in the University of Maryland School of Medicine and received his M. D. degree in 1934.

Doctor Goodhand served his internship at the University of Maryland Hospital in Baltimore, 1934-36, and served as assistant resident in obstetrics at the same hospital in 1936-37. He completed his residency training at Baltimore City Hospital, 1937-38.

He was licensed to practice medicine in West Virginia in 1938 and established his practice in Parkersburg that same year. He was certified by the American Board of Obstetrics and Gynecology in 1947.

During World War II, Doctor Goodhand served in the Medical Corps of the United States Army and was Chief of the Surgical Department of the 55th Station Hospital. He served overseas for 34 months and was released in 1946 with the rank of Lieutenant Colonel.

Doctor Goodhand served as President of the Parkersburg Academy of Medicine in 1951 and had served two terms as President of the West Virginia Obstetrical and Gynecological Society. He was a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology.

He served two terms as a member of the Council of the State Medical Association and was named Vice President in 1961, President Elect in 1962, and President in 1963. He completed a term as Chairman of the Council in August, and was serving as Councilor-at-Large at the time of his death.

Doctor Goodhand maintained an active interest in civic affairs and served as chairman of the Parkersburg Municipal Charter Board, 1960-61. He served as chief of the obstetrical service at St. Joseph's and Camden-Clark Memorial hospitals, and served terms as president of both hospital staffs.

He is survived by his widow, Mrs. Helen Willis Goodhand; a daughter, Mrs. Thomas R. Gill of Lake Tahoe, California; a granddaughter, Lisa Gill; and a sister, Mrs. Gwynn Bowie of Upper Marboro, Maryland.

AMA CONVENTION IN PHILADELPHIA

The American physician is well aware that he must keep abreast of new findings in therapy and research to be able to provide the best possible care for his patients. He must know about new drugs and their uses and possible side effects. He must know about new techniques of surgery. He must know of the promising leads toward solution of now baffling physical ills. And he must know the sometimes small but often important new successes in finding better ways to treat the already treatable diseases.

There's no argument about the premise that the physician must keep learning. The problem is how. With the average American physician now working a 58-hour week, and many putting in hours far above the average, how can the physician find the time to study and keep abreast?

One of the most compact methods of checking up on new developments is to attend the annual Clinical Convention of the American Medical Association. The program of this convention is designed primarily for the man in practice. The speakers will read papers that bring to the man in practice the latest findings of others in his area.

This year the Clinical Convention will be held in my home state of Pennsylvania, November 28-December 1, in Philadelphia.

The Philadelphia meeting offers an excellent scientific program. Topics of wide interest will be discussed by outstanding teachers. All of the various sessions and workshops will contribute to the continuing education of the practicing physician.

It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the Clinical Convention—James Z. Appel, M. D., President of the American Medical Association.

GENERAL NEWS

392 Attend Rural Health Conference At Jackson's Mill on Sept. 30

An attendance record was set at the 18th Annual Rural Health Conference which was held at Jackson's Mill on September 30.

Registration totaled 392, far exceeding the previous record of 303 set in 1964.

Dr. W. Wyan Washburn of Boiling Springs, North Carolina, Chairman of the AMA Council on Rural Health, is shown with Dr. Martha Jane Coyner of Harrisville, Chairman of the Rural Health Committee of the State Medical Association, just before the 18th Annual Rural Health Conference opened. Doctor Washburn delivered the keynote address.

The West Virginia State Medical Association sponsors the conference annually under the auspices of its Rural Health Committee and with the cooperation of the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Department of Health, the West Virginia Congress of Agriculture and the Cooperative Extension Service of West Virginia University.

Doctor Coyner Presiding Officer

The conference was called to order at 10 A. M. by Dr. Martha Jane Coyner, Chairman of the State Medical Association's Rural Health Committee. The Rev. Joseph P. DeBardi, Minister of the First Methodist Church in Clarksburg, gave the invocation.

Doctor Washburn Keynote Speaker

Dr. W. Wyan Washburn of Boiling Springs, North Carolina, Chairman of the Council on Rural Health of the American Medical Association, delivered the keynote address.

Doctor Washburn told the gathering that prevention remains the key to an effective health program. He said each home should become a medical center in itself with each member of the family accepting a share of responsibility for its health practices.

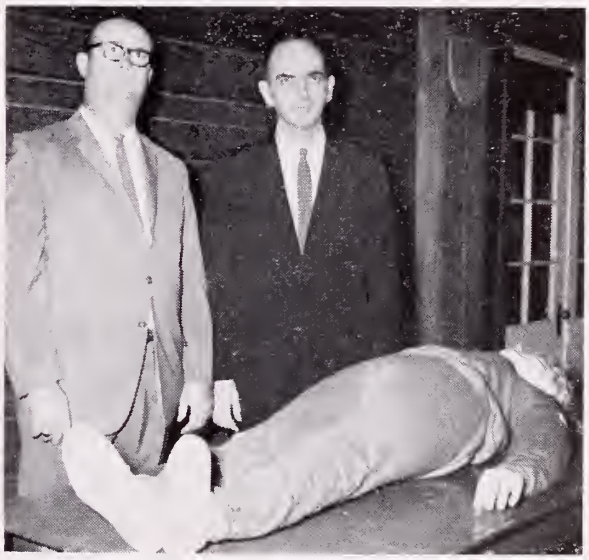
The changing character of cities and their suburban surroundings, Doctor Washburn observed, offers new challenges to good health for those moving from rural areas to metropolitan centers. In this connection, he mentioned air and water pollution, waste treatment and crowded living conditions.

'Cardio-Pulmonary Resuscitation'

Representatives of the State Health Department presented an interesting program on "Cardio-Pulmonary Resuscitation." The program was illustrated with slides and a motion picture.

Participating were Dr. Edwin C. Neville, a Charleston thoracic surgeon and Consultant to the Heart Disease Control Bureau of the State Health Department, and Mr. Calvin C. Paul, a Public Health Advisor for the Department.

Following this part of the program, the West Virginia State Medical Association was host at a luncheon for all attending the conference.



Mr. Calvin C. Paul, Public Health Advisor for the State Department of Health (left), and Dr. Edwin C. Neville of Charleston, a Consultant to the Department, presented a program on "Cardio-Pulmonary Resuscitation." Manikin in foreground was used for demonstration purposes.

Address by Doctor Parks

Dr. Seigle W. Parks, President of the West Virginia State Medical Association, opened the afternoon session with an address of welcome. Doctor Parks discussed the doctor shortage in rural areas and mentioned ways the situation might be alleviated.

Panel Discussion

The final feature of the program was a panel discussion entitled "As The Twig Is Bent. . .", which concerned emotional problems from childhood to college age.

Doctor Coyner was moderator and panelists were Dr. Robert L. Vosburg, Professor of Psychiatry at the West Virginia University School of Medicine; Dr. W. Gene Klingberg, Professor of Pediatrics at the School of Medicine; and Mr. Joseph C. Gluck, Director of Student Affairs at WVU.

The presentations by the panelists elicited a number of questions from the audience.

These three faculty members at West Virginia University participated in a panel discussion of emotional problems of persons from childhood to college age at the Rural Health Conference. Left to right: Mr. Joseph C. Gluck, Director of Student Affairs; Dr. Robert L. Vosburg, Professor of Psychiatry in the School of Medicine; and Dr. W. Gene Klingberg, Professor of Pediatrics in the School of Medicine.

Mrs. D. N. Thomas New President Of W. Va. Cancer Society

Mrs. D. N. Thomas of Weirton was elected president of the West Virginia Division of the American Cancer Society during the annual meeting of that organization which was held in Wheeling, October 8-10.

Mrs. Thomas succeeds Dr. Bernard Zimmermann of Morgantown, Professor of Surgery at the West Virginia University School of Medicine.

Dr. David B. Gray of Charleston was elected vice president of the cancer organization, and Miss Marjorie Scott of Wheeling was reelected secretary.

Also reelected was the treasurer, Mr. Max W. Saunders of Charleston.

Dr. L. Walter Fix of Martinsburg was named chairman of the executive committee.

State Physicians To Participate In SMA Meeting in Houston

Several West Virginia physicians will appear as speakers on the scientific program for the 59th Annual Meeting of the Southern Medical Association, which will be held in Houston, Texas, November 1-4.

Dr. Albert C. Esposito of Huntington, Chairman of the Council of the West Virginia State Medical Association, will serve on a panel on Ophthalmic Surgery, which will be a feature of the program of the Section on Ophthalmology. The panel discussion will be conducted on November 1.

Doctor Esposito is a member of the SMA Council and the Executive Committee.

Associate Councilors from West Virginia are Drs. Nime K. Joseph of Wheeling, Thomas H. Blake of St. Albans, H. Charles Ballou of White Sulphur Springs, J. C. Huffman of Buckhannon and James T. Spencer of Charleston.

Dr. Robert L. Vosburg, Chairman of the Department of Psychiatry at the West Virginia University School of Medicine, will serve as discussant for a paper that will be presented before three different sections of the SMA. The paper is entitled "Post Concussion Syndrome: Its Etiology and Treatment" and it will be presented by Dr. Michael M. Gilbert of Miami, Florida.

Drs. H. Charles Ballou and Arnold J. Brody, both of White Sulphur Springs, will present papers before the Section on Industrial Medicine and Surgery, of which Doctor Ballou is Chairman.

Doctor Brody's paper is entitled "Glaucoma Detection and Disease Association in the Periodic Health Examination." Doctor Ballou will address the section on "Results of Routine Cholecystography in Annual Physical Exams."

Dr. David H. Smith of Wheeling will speak on "Referral of Patients to a Psychiatrist" at a meeting of the Section on Neurology and Psychiatry on Thursday, November 4.

Dr. James T. Spencer of Charleston will serve as discussant for a paper which will be presented Tuesday, November 2, before the Section on Otolaryngology. The paper—entitled "Electrocoagulation Hemostasis in Tonsillo-adenoidectomy—was prepared by Drs. Ben T. Withers, Jr., Ralph J. Coppola, James E. McMurray and Fred P. Thomas, all of Houston, Texas.

A paper on "Long-Term Results of Chemical Face Peel" will be presented on Tuesday before the Section on Plastic and Reconstructive Surgery by Dr. Clyde Litton, also of Charleston.

Dr. John W. Trenton of Kingwood will participate in a symposium on "Current Status of Renal Transplantation" on Tuesday. The symposium will be a feature of the program of the Section on Urology.

Mr. Clayton Eugene Linkous, Jr., a senior in the West Virginia University School of Medicine, will be a medical student representative at the four-day SMA meeting.

19th Annual AMA Clinical Convention Planned in Philadelphia

Dr. James Z. Appel of Lancaster, Pennsylvania, President of the American Medical Association, will preside at the 19th Annual Clinical Convention of the AMA, which will be held in Philadelphia, November 28-December 1.

James Z. Appel, M. D.

Doctor Appel was installed as President of the AMA at the Annual Meeting in New York City last June. He was named a member of the AMA Board of Trustees in 1957 and served for several years as Vice Chairman. He relinquished this position when he was named President Elect at the Clinical Convention in Miami Beach last year.

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington are the official AMA delegates from the West Virginia State Medical Association and will attend all sessions of the House of Delegates. Alternate delegates are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Scientific Program

A scientific program geared to the needs of the practicing physician has been arranged for the meeting. More than 300 physicians will participate in giving the four-day program of lectures, exhibits, motion pictures, color television, fireside conferences, and breakfast roundtables.

Program for Practicing Physicians

Some of the topics on the scientific program include: ulcerative colitis, gram-negative bacterial infections, a medical-surgical review of cardiovascular surgery, drug therapy in rheumatology, and cancer chemotherapy and preventive surgery.

The practicing physician will be able to participate in one of the convention's new features. Clinical workshops on diabetes, examination of the heart, management of common eye problems, and the solution of selected diagnostic and therapeutic problems will be conducted by outstanding teachers.

Also new will be a postgraduate course in cardiovascular therapeutics. It will be offered in addition to the popular course on gynecology and obstetrics begun at the Clinical Convention last year.

Fireside Conferences

Twelve fireside conferences will be held on Sunday evening, November 28, at the Warwick Hotel. They will be joint sessions of the American College of Chest Physicians and the AMA.

Medical Aspects of Sports

The annual AMA Conference on the Medical Aspects of Sports will be held on the first day of the meeting, November 28, in the Benjamin Franklin Hotel. Among the discussion topics are management of head, neck and knee injuries; weight control in wrestling; estimation of an athlete's readiness for sports, and help for the atypical athlete in finding a place in sports.

Doctor Appel will speak on "Sports Medicine in Perspective" at a luncheon session.

The complete scientific program for the Clinical Convention was published in the October 25 issue of *JAMA*.

Dr. Thomas L. Harris Named Member Of WVU Board of Governors

Dr. Thomas L. Harris of Parkersburg was recently appointed by Gov. Hulett C. Smith to a nine-year term on the West Virginia University Board of Governors. He succeeds Raymond E. Salvati, who now resides in Fort Lauderdale, Florida.

Thomas L. Harris, M. D.

Doctor Harris, who is a Past President of the West Virginia State Medical Association, previously served as a member of the Board from 1945 to 1960. He was President of the Board in 1949-50 and 1959-60.

In 1960, an honorary degree of Doctor of Science was conferred upon Doctor Harris during dedicatory ceremonies for the University Hospital at the West Virginia University Medical Center.

Doctor Harris was graduated from the University and attended the two-year School of Medicine. He received his M. D. degree in 1910 from Jefferson Medical College and has practiced his specialty of surgery in Parkersburg since that time.

Dr. Guy R. Post Admitted as Fellow Of Royal Society of Health

Dr. Guy R. Post of Fairmont was notified recently that he had been admitted as a Fellow of the Royal Society of Health.

The Society was founded in England in 1876 and the Patron is Her Majesty the Queen.

Doctor Post, who has served since 1957 as Health Officer in Marion County, is a native of Roanoke, Lewis County. He was graduated from Glenville State Teachers College and he received his M. D. degree in 1916 from the University of Maryland School of Medicine. He received his M.P.H. degree in 1939 from Johns Hopkins University School of Public Health and Hygiene.

Only 20 Nursing Homes Receive Licenses

Professional care for state nursing homes was urged by State Health Director N. H. Dyer in a recent issue of the "State of the State's Health." He noted apathy on the part of physicians in their participation in the nursing home program and said that registered nurses responsible for the supervision of nursing care in West Virginia nursing homes should be in close contact at all times with medical supervision.

Doctor Dyer reported that, to date, only 20 nursing homes in the state have been issued licenses to operate for the present fiscal year and some of these were issued with reservations. Four licenses are pending certification from the State Fire Marshal; 17 have not yet complied with health department regulations; 7 have complied with neither health department nor state fire regulations, and two licenses are pending legal action.

According to Doctor Dyer, there are only six nursing homes in West Virginia providing 269 nursing home beds which meet the revised state regulations and standards. He said that there is a tremendous increase in the operation of unlicensed nursing homes in most areas of the state in order to meet the increasing demand for nursing home beds. These homes, constructed of materials which do not meet the requirements of the licensing law for nursing homes, prevent the upgrading of West Virginia's nursing homes.

Doctor Dyer added that there were some high standard facilities in the state providing excellent nursing home care for patients and some quality patient care programs being conducted in substandard physical facilities. However, too little thought has been given to the patients relegated to these substandard facilities for the remainder of their lives.

Doctor Dyer said, "Attempts should be made on the local level by physicians, registered nurses and nursing home administrators and owners to determine the necessary participation by physicians needed in each nursing home program to insure safe ethical patient care."

In another issue of the "State of the State's Health," Doctor Dyer discussed projects to enable the State Health Department to meet the health problems arising from the use of radiation within the state. These projects included correcting dental and medical x-ray units; radiation safety surveys of state institutions and local health department clinics to investigate factors affecting dosage received by patients, clinics and hospital personnel, and a registration and inspection program involving state veterinarians and private hospitals and clinics.

Doctor Dyer expressed hopes to encompass not only surveys and services on x-ray machines, but natural occurring radioactive material such as radium, radioactive isotopes and an expanded environmental surveillance program. When the program is expanded, he stated, additional sampling points throughout the state will be established for the collection of air, milk and water samples for routine radio-chemical analysis. In the future, he concluded, the state may assume responsibility of licensing and control of radioactive isotopes used within the state which is currently a function of the U. S. Atomic Energy Commission.

Gov. Smith Appoints Dr. Myers To State Health Board

Dr. Hu C. Myers of Philippi was appointed by Gov. Hulett C. Smith in September to a vacancy on the State Board of Health.

A native of Nestorville in Barbour County, Doctor Myers succeeds Dr. William D. McClung of Ripley, who resigned. The unexpired terms ends June 30, 1967.

Doctor Myers formerly was a member of the Advisory Board to the State Board of Health. Governor Smith appointed Dr. Russel Kessel of Charleston to succeed Doctor Myers on the Advisory Board.

Doctor Myers is a Diplomate of the American Board of Surgery. He is a former member of the Council of the West Virginia State Medical Association and has served as President of the Barbour-Randolph-Tucker Tri-County Medical Society. He received his M. D. degree in 1927 from the Emory University School of Medicine.

Doctor Andrews To Lecture At U. of Va. Meeting

Dr. Charles E. Andrews of Morgantown will be a member of the guest faculty for a Conference on Respiratory Disease which will be held at the University of Virginia School of Medicine in Charlottesville. November 19-20.

Doctor Andrews, Professor of Medicine at West Virginia University School of Medicine, will present a paper on "Diagnostic Studies for Recognizing Pulmonary Tuberculosis."

The American Academy of General Practice has approved eight hours of credit for members who attend the conference.

No registration fee is required and additional information may be obtained by writing to Continuation Education Program, Box 329, University of Virginia Hospital, Charlottesville, Virginia.

STATEMENT REQUIRED BY THE ACT OF OCTOBER 23, 1962: SECTION 4369, TITLE 39, UNITED STATES CODE SHOWING THE OWNERSHIP, MANAGEMENT AND CIRCULATION OF THE WEST VIRGINIA MEDICAL JOURNAL.

The West Virginia Medical Journal is published monthly at 401 Atlas Building, 1031 Quarrier Street, Charleston, West Virginia 25301.

The names and addresses of the publisher, editor and managing editor are: Publisher, the West Virginia State Medical Association, Box 1031, Charleston, W. Va. 25324; Editor, George F. Evans, M. D., 122 South Sixth Street, Clarksburg, West Virginia; Managing Editor, Mr. William H. Lively, Box 1031, Charleston, W. Va. 25324.

The known bond holders, mortgagees, and other security holders owning or holding one per cent or more of total amount of bonds, mortgages or other securities are: None.

The average number of copies each issue during preceding twelve months are: (A) Total number of copies printed: 2,500; (B 1) Paid circulation through dealers and carriers, street vendors and counter sales: None; (B 2) Paid circulation through mail subscriptions: None; (C) Total paid circulation: 1,549; (D) Free distribution by mail, carrier, or other means, 691; (E) Total distribution: 2,240; (F) Office use, left-over, unaccounted, spoiled after printing: 260; (G) Total: 2,500.

I certify that the statements made by me above are correct and complete.

(Signed) William H. Lively,
Managing Editor

39 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board of West Virginia licensed 39 physicians, 23 by direct examination and 16 by reciprocity, at a meeting held at The Capitol in Charleston, July 12-14, 1965. The following physicians were licensed by direct examination:

Abraham, Nazem, Huntington
Baise, George Richard, Barboursville
Barile, John Lee, Cuyahoga Falls, Ohio
Bivens, Spencer Lee, Jr., Charleston
Buchanan, Harry Glenn, Huntington
Dotson, Thomas Owen, Morgantown
Goerlich, Berthold Herbert, Elkins

Hanshaw, William Joseph, Dunbar
Hidalgo, Joaquin, Elgin, Illinois
Judy, Lewis Martin, Elyria, Ohio
Karnasiewicz, Waldemar L., Charleston
King, Roger Edward, Richmond, Virginia
Lemley, Ruby Eileen, Fairview
Licata, Antonio Samuel, Weirton

Lilly, James Aaron, Huntington
Metz, Karl Von, Jr., Seal Beach, California
Palkot, John Sylvester, Roanoke, Virginia
Ramirez, Rigoberto, Buckhannon
Richardson, Thomas Edward, Marlinton
Sayfie, Ernest George, Charleston
Schmidt, James Lee, Charleston
Stewart, Charles V., Jr., Houston, Texas
Wilkerson, James Eastman, Whitesville

The following is a list of the physicians who were licensed by reciprocity:

Butler, Herbert Harriss, Jr., Welch
Carter, James Monroe, Parkersburg
Clopton, William Malvern, Beckley
Conner, Clarence Henry, Shinnston
Desrosiers, Norman Alfred, Charleston
Farr, Joseph Louis, Wheeling

Haymond, Thomas Arnette, Freeport, Illinois
Herm, Robert James, Morgantown
Holtrop, Hugh Robert, Wheeling
McFadden, William Moffitt, III, Morgantown
Mullins, Lawrence Darrell, Welch

Packovich, Milan John, Weirton
Sauder, Howard Burkholder, Wheeling
Sprinkle, Philip Martin, Morgantown
Stewart, Sherrill Bryce, Charleston
Thomas, Edward Lamar, Beckley

PG Course for Internists

The American College of Physicians will sponsor a postgraduate course on "Psychiatry For The Internist" in Los Angeles, December 6-10.

Registration fees will be $60 for ACP members and $100 for non-members. Further information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Dr. Seigle W. Parks (right), President of the West Virginia State Medical Association, was guest speaker at the annual joint meeting of the Central West Virginia Medical Society and the Woman's Auxiliary, which was held in Buckhannon on September 29. Others in the picture are (left to right): Dr. R. L. Chamberlain of Buckhannon, who was re-elected Secretary of the local Society; Dr. Charles T. Lively of Weston, who was elected President of the Society; and Dr. Ira F. Hartman of Buckhannon, the retiring President.

Three West Virginians Named To Federal Committee

Dr. Paul A. Miller, President of West Virginia University, has been named Chairman of the Appalachian Regional Commission's Advisory Committee on Health.

Mr. John L. Sweeney, Federal Co-Chairman of the Commission, and Gov. Edward T. Breathitt of Kentucky, the State Co-Chairman, announced the appointment.

Other members of the Committee will include Dr. Mildred Mitchell-Bateman, Director of the West Virginia Department of Mental Health, and Dr. N. Allen Dyer, Assistant Director of the State Health Department.

The Advisory Health Committee will advise the Appalachian Commission on means of providing a regional medical program to assist residents of the 12-state Appalachian Region. The Appalachian Regional Development Act authorizes $69 million for the construction and operation of health facilities in the Appalachian area.

AMA-ERF Biomedical Institute Dedicated

The American Medical Association Education and Research Foundation's Institute for Biomedical Research was dedicated in Chicago on October 11.

A scientific symposium was part of a day of activities marking the official opening of the research institute, which supports fundamental inquiries into basic life processes.

Other dedication activities included tours of the nine-story addition to the AMA Headquarters Building, a luncheon, reception and dinner.

Dr. James Z. Appel, President of the AMA, was host for the dedication ceremonies, and Dr. Raymond M. McKeown, President of AMA-ERF, made the dedicatory address.

Dr. C. A. Hoffman Named Member Of HEW Advisory Committee

Dr. C. A. Hoffman of Huntington has been selected by the Secretary of the Department of Health, Education and Welfare to serve on a technical committee named to help work out operational details of the new Medicare program.

C. A. Hoffman, M. D.

Doctor Hoffman was notified of his appointment by HEW Secretary John W. Gardner. He will serve on a committee which will consider various aspects of services to be provided Medicare recipients by physical specialists in hospitals.

Doctor Hoffman, a Past President of the West Virginia State Medical Association, is a member of the Council on Medical Service of the American Medical Association and also serves as a member of the executive committee of the National Association of Blue Shield Plans.

972 Companies Provide Health Insurance to the Public

Insurance companies providing health care expense protection to the American public numbered 972 by the end of 1964, the Health Insurance Institute reported recently. The Institute said that this was a record high. Last year 69 more companies provided health insurance than did so in 1963.

The firms providing health insurance included 653 life insurance companies, 278 casualty insurance firms, and 41 monoline companies. According to the Institute, these insuring organizations generally provided hospital, surgical, and medical expense protection. A substantial number also provided benefits toward the replacement of earned income lost as the result of disability.

Of the 972 companies in the health insurance field, 627 provided group health insurance programs, and 893 issued individual and family insuring programs. Companies offering both group and individual-family policies numbered 543 at the 1964 year-end. In 1964, insurance companies protected 93.2 million persons under hospital expenses programs. Of these, 89.6 million had surgical expense protection and 55.2 million had regular medical coverage.

Insurance companies also helped protect nearly 36.2 million wage earners against the loss of income during disability. Benefits distributed by companies under all these health insurance programs totaled $4,658,000,000 in 1964, the Institute said.

Over-all, more than 1,900 insuring organizations provided health insurance in the United States last year, covering over 151 million persons. Total benefits paid (including insurance companies) came to $8.7 billion.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1965

Nov. 1-4—Southern Medical Assn., Houston.
Nov. 1-5—Am. Dietetic Assn., Cleveland.
Nov. 9-13—Am. Medical Women's Assn., Chicago.
Nov. 12-13—Soc. of Clinical Surgery, Jackson, Miss.
Nov. 14-19—American Acad. of Oph. & Otol., Chicago.
Nov. 22-24—Med. Soc. of D. C., Washington.
Nov. 27-28—ACCP, Philadelphia.
Nov. 27-Dec. 3—Radiological Soc. of N. America, Chicago.
Nov. 28-Dec. 1—AMA Clinical Meeting, Philadelphia.
Dec. 1-4—Am. Acad. for Cerebral Palsy, Cleveland.
Dec. 4-9—Am. Acad. of Dermatology, Chicago.
Dec. 5-7—Am. Soc. of Hematology, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

Jan. 19—Soc. of Adolescent Psychiatry, New York.
Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Jan. 28-30—Sou. Radiological Conf., Point Clear, Ala.
Feb. 2-6—Am. Col. of Cardiology, Chicago.
Feb. 3-9—Cong. of Medical Education, Chicago.
Feb. 8-12—Am. Col. of Radiology, Chicago.
Feb. 14-18—Am. Protestant Hosp. Assn., Dallas.
Feb. 21-23—Am. Acad. of Allergy, New York.
Feb. 23—Nat. Multiple Sclerosis Soc., New York.
Feb. 28-March 3—Southeastern Surgical Cong., Atlanta.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 1-7—AAGP, Boston.
April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP, Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 10-14—ACS, San Francisco.

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Each capsule contains:

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Therapeutic Effects
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

Contraindications
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Average Dosage
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

Note: The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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WVU Medical Center
–News–

DR. Virginia Apgar of Tenafly, New Jersey, will speak on "Early Diagnosis of Hidden Congenital Anomalies" at the Medical Center on November 19.

Virginia Apgar, M. D.

The appearance of Doctor Apgar, a noted specialist on the problems of newborn infants, is being sponsored by the School of Medicine's Department of Pathology. She is Head of the Division of Congenital Malformations for the National Foundation-March of Dimes.

Doctor Apgar is the creator of the "Apgar Score," which is a clinical evaluation made within 60 seconds after a birth to determine the newborn's over-all condition.

Before joining the National Foundation in 1959, Doctor Apgar was Professor of Anesthesiology at Columbia University College of Physicians and Surgeons, where she received her medical training. She is the author of more than 40 articles on anesthesiology, resuscitation and congenital anomalies in both professional and lay journals.

Psychiatric Staff Enlarged

Four psychiatrists have joined the part-time faculty of the Department of Psychiatry.

The new clinical associate professors are Drs. David H. Smith of Wheeling, B. D. Smith of Clarksburg, Garnett Bradley of Fairmont and Cornelia Wilbur of New York, who will assume a position in the state soon.

Dr. Robert L. Vosburg, Chairman of the Department, said the new staff members are needed to meet an increased demand for psychiatric services and to provide postgraduate training facilities. Doctor Vosburg said Dr. David E. Edwards of the University Health Service also will serve as a part time instructor in psychiatry.

Cancer Research Seminar

A research seminar on "Lymphatic Dissemination of Cancer" will be held at the Medical Center on November 16.

The speaker will be Dr. Bedrettin H. Gorgun, Instructor in Surgery. The seminar is the third in a series of nine being sponsored during the current school year by the Department of Surgery.

The programs will be held on the third Tuesday of each month through May.

• **Compiled from material furnished by Arthur V. Cierva, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Lectures at the Medical Center

Dr. Sheldon J. Segal of New York City presented a lecture at the Medical Center on October 25 on "The Role of RNA in the Regulatory Action of Estrogen."

Doctor Segal is director of the Bio-Medical Division, the Population Council, The Rockefeller Institute. He received his Ph.D. degree in embryology and biochemistry in 1952 at the University of Iowa.

He is the author of more than 30 publications in the fields of endocrinology and embryology.

Dr. Martin FitzPatrick of Saranac Lake, New York, director of the O'Donnell Memorial Research Laboratories at Will Rogers Hospital, visited the School of Medicine, October 11-12.

Dr. Charles E. Andrews, Professor of Medicine, said Doctor FitzPatrick was the first of four visiting professors in pulmonary diseases scheduled to visit the School during the current school year.

Doctor FitzPatrick delivered a lecture on "Biochemical Studies of Pulmonary Connective Tissue."

Dr. James G. Robson of London, England, lectured at the WVU Medical Center on September 24.

Doctor Robson's paper was entitled "The Neurological Control of Respiration." He occupies the Chair of Anesthetics at the University of London and heads the Department of Anesthetics at Hammersmith Hospital, also in London.

Doctor Robson spent five days visiting the Medical Center under sponsorship of the Division of Anesthesiology of the School of Medicine.

Grant for Doctor Schmidt

Dr. Ronald E. Schmidt of the Department of Pediatrics at the School of Medicine has been awarded a Mead Johnson grant for pediatric research.

The award was one of seven totaling almost $30,000 from the American Academy of Pediatrics. Doctor Schmidt's subject is "Precordial Motion Studies in Outflow Obstruction of the Right Ventricle."

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The Month in Washington

PRESIDENT Johnson has signed into law a modified version of the controversial, so-called DeBakey legislation authorizing establishment of regional cooperative programs of research, training and related patient care in the fields of heart disease, cancer, stroke and related diseases.

A total of $340 million in federal funds will be available during the next three years to help universities, medical schools, research centers and other public or nonprofit institutions, such as hospitals, and agencies in (1) planning, (2) conducting feasibility studies and (3) operating pilot projects.

The legislation was amended in the House, as recommended by the American Medical Association, to make it less objectionable to the medical profession. Dr. James Z. Appel, President of the AMA, said the some 20 House amendments were substantial and should "allay many of the fears the medical profession had about the original bill."

But even so, the AMA could not support the amended legislation, Doctor Appel said, "because we believe it still introduces an undesirable concept."

The original bill called for establishment of regional medical complexes and would have included "other major diseases."

As enacted into law, the programs are to be carried out "in cooperation with practicing physicians." Patient care is limited to that "incident to research, training or demonstrations." No patient can receive such treatment except on referral of a practicing physician.

Construction is limited to remodeling and renovation of buildings and replacement of obsolete equipment.

The Surgeon General of the Public Health Service is designated as the official responsible for final approval of federal grants under the program. However, he can act only upon the recommendation of a national advisory council. And an application for a federal grant first must be approved by a local advisory committee. Both the national and local committees must include practicing physicians.

Present federal plans call for starting eight regional programs during the first year and 17 more during the next two years. As of this writing, none of them had been announced.

Miscellaneous

The Department of Health, Education and Welfare has ruled that physicians are not required to sign racial non-discrimination pledges in order to receive payment for treating federal-state welfare patients.

• From the Washington Office of the American Medical Association.

The ruling followed protests of some state medical societies and individual physicians when some state health departments interpreted the new Civil Rights Act as requiring the signing of such a pledge. The societies and physicians protested that such a pledge would constitute an unnecessary federal interference in the patient-physician relationship.

The recent special meeting of the AMA House of Delegates adopted a resolution pointing out that non-discrimination conditions under the Principles of Medical Ethics and "willingly self-imposed by the medical profession far exceed any pledge of this nature demanded by a federal bureaucracy."

The House Ways and Means Committee has postponed until next year consideration of legislation that would liberalize the so-called Keogh law. The present law permits physicians and other self-employed persons to defer income taxes on a maximum of $1,250 a year set aside in a retirement fund. A bill before the committee would increase the maximum to $2,500 a year.

The Public Health Service reported only 35 cases of polio during the first 34 weeks of this year, a record low for the period.

During the same period this year, only 96 cases of diphtheria were reported. This figure compared with a five-year median of 244 cases in the same number of weeks.

Dr. William H. Stewart, 44-year-old Public Health Service career officer, is the new PHS Surgeon General.

He succeeded Dr. Luther Terry who resigned to become vice president of the University of Pennsylvania.

Recognized as an expert in the field of public health administration, Doctor Stewart had headed the National Heart Institute since last August. For the previous two years, he served as assistant to the special assistant to the HEW Assistant Secretary for Health and Medical Affairs.

After being graduated from the Louisiana State University School of Medicine, he served in the Army Medical Corps from 1946 to 1948. He gave up a pediatric practice in Alexandria, Louisiana, in 1951 to join the PHS Commissioned Corps.

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Obituaries

VINCENT TAPP CHURCHMAN, JR., M. D.

Dr. V. T. Churchman, Jr., of Charleston, an eye, ear, nose and throat specialist, died on October 1 after suffering a heart attack. He was 66.

A native of Charleston, Doctor Churchman attended Augusta Military Academy and the University of Virginia before receiving his M. D. degree in 1923 from Jefferson Medical College in Philadelphia. He practiced medicine in Charleston for 40 years.

Doctor Churchman was a member of the Kanawha Medical Society, the West Virginia State Medical Association and the American College of Surgeons. He was a charter member of the West Virginia Academy of Ophthalmology and Otolaryngology.

Survivors include the widow; and two daughters, Mrs. A. E. Withrow and Mrs. Thomas Kelly, both of Charleston.

* * * *

OKEY LAMBERT HAMILTON, M. D.

Dr. Okey L. Hamilton, 85 of Huntington, died in a hospital in that city on September 29.

Doctor Hamilton was born at Bearsville in Tyler County and attended Marshall University. He received his M. D. degree in 1911 from the Medical College of Virginia.

He was a member of the Cabell County Medical Society, the West Virginia State Medical Association and the American Medical Association.

Survivors include the widow, Mrs. Susan Elizabeth Gillespie Hamilton of Huntington; and two brothers, H. Cliff Hamilton of Charleston and Bruce Hamilton of Middlebourne.

* * * *

THAD TAYLOR HUFFMAN, M. D.

Dr. Thad T. Huffman, 53, died at his home in Keyser on October 4 after suffering a heart attack.

Doctor Huffman was a native of Keyser and returned there to practice after he received his M. D. degree from Hahnemann Medical College in Philadelphia in 1938. He also had attended Potomac State College and West Virginia University.

He was a member of the Potomac Valley Medical Society, of which he was President in 1949-50, the West Virginia State Medical Association, the American Medical Association, the American Academy of General Practice and the American Academy of Chest Physicians.

Doctor Huffman was physician for Potomac State College and was health officer for the City of Keyser.

Surviving are the widow, Mrs. Mary Stevenson Huffman; daughters Mary Sue, a junior at West Virginia University, and Janet Shawn, a student at Keyser High School; a son, Thad Stevenson, an eighth grade student; and one brother, Fred N. Huffman of Keyser.

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Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
Joann Green, R. N.
June Althar, R. N.
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Evelyn Forester, R. T.

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Lester L. Cline, Manager
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County Societies

CENTRAL WEST VIRGINIA

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was guest speaker at the fall meeting of the Central West Virginia Medical Society, which was held at West Virginia Wesleyan College in Buckhannon on September 29.

Doctor Parks spoke of the need to attract new physicians to rural areas and urged each doctor to play a part in the recruiting effort.

Dr. Charles T. Lively of Weston was elected President for the coming year, succeeding Dr. I. F. Hartman of Buckhannon. Dr. R. L. Chamberlain of Buckhannon was re-elected Secretary-Treasurer.

More than a dozen members attended the dinner meeting in addition to wives and guests.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on September 8.

Members of the staff of the Grace Hospital were in charge of the scientific program and Dr. Guy E. Irvin presented a film on chronic bronchitis and emphysema.

Mr. Dennis McCutcheon appeared before the Society to request that a physician be appointed as official advisor to the local chapter of the Council of Southern Mountains. Following discussion, Dr. A. J. Villani was elected to serve as advisor to the organization.

The Society paid tribute to Mrs. Stephen Mamick for her outstanding work in directing young people into the field of medicine.

Eighteen members and five guests attended the meeting.—David J. Skewes, M. D., Secretary.

* * * *

MERCER

The Mercer County Medical Society met jointly with the Mercer County Bar Association on September 29 at the Sahara Club in Bluefield.

The guest speaker at the dinner was Mr. Douglas McKay, an attorney from Columbia, South Carolina. He gave a most interesting and informative talk.

Other guests included Drs. S. J. Misak of Bluefield and George E. Lipscomb of the University of Virginia Hospital in Charlottesville, and Judge Howard Jarrett of Mercer County.

Dr. Sam Milchin, President of the Mercer County Medical Society, presided at the meeting.—John J. Mahood, M. D., Secretary.

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Fourth Vice President: Mrs. Rupert W. Powell, Fairmont
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Corresponding Secretary: Mrs. M. L. White, Jr., Huntington
Parliamentarian: Mrs. D. E. Greenfeltch, Wheeling

CENTRAL WEST VIRGINIA

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at a meeting of the Woman's Auxiliary to the Central West Virginia Medical Society which was held at West Virginia Wesleyan College in Buckhannon on September 29.

Mrs. Smith discussed the influence physicians' wives can have in bringing new physicians into a community. Mrs. Smith also stressed the AMA-ERF program, international health and mental health needs. She donated a porcelain figurine to be used in AMA-ERF Fund raising and distributed a box of "dream pets" for the same purpose.

Earlier in the evening, Auxiliary members joined their husbands for a dinner meeting. The guest speaker was Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association—Mrs. John E. Echols, Corresponding Secretary.

* * * *

HARRISON

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association, was a guest of honor at a tea sponsored by the Woman's Auxiliary to the Harrison County Medical Society which was held at the home of Dr. and Mrs. James A. Thompson in Clarksburg, September 16.

Other honored guests were the following officers of the Auxiliary to the State Medical Association: Mrs. Hu C. Myers of Philippi, President Elect; Mrs. Claude R. Davisson of Weston, Second Vice President; Mrs. Rupert W. Powell of Fairmont, Fourth Vice President; and Mrs. M. Bruce Martin of Huntington, State Chairman of AMA-ERF.

The County Auxiliary's theme for this year is: "Never one thing and seldom one person can make for a success. It takes a number of them merging into one perfect whole."

The Woman's Auxiliary to the Harrison County Medical Society met October 7 at the Clarksburg Country Club.

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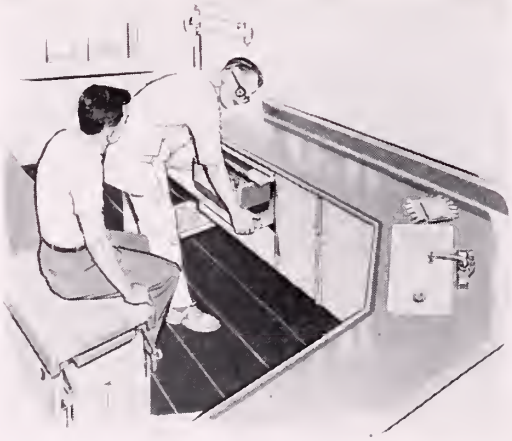

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WOMAN'S AUXILIARY—(Continued)

Mrs. John D. H. Wilson, Community Service Chairman, presented Mr. William B. Simpson of Consolidated Gas Company, who spoke about the new family service counseling program.

Mrs. F. J. Januszeski, a new member, was introduced.—Mrs. James E. Wilson, Jr.

* * * *

KANAWHA

"Let's Get Started On The Direct Line" was the theme for the first fall meeting of the Woman's Auxiliary to the Kanawha Medical Society, which was held on September 14.

The activities of the Auxiliary for the coming year were reviewed and the following new members were introduced: Mesdames A. G. Capinpin, Seigle W. Parks, Rodolfo K. Stock, and M. Kovacevich—Mrs. J. L. Mangus, Publicity Chairman.

* * * *

LOGAN

The Woman's Auxiliary to the Logan County Medical Society met September 29 at the home of the President, Mrs. Walter E. Brewer, in Logan.

Mrs. Ray M. Kessel gave a report on the annual meeting of the Woman's Auxiliary to the West Virginia State Medical Association, which was held at The Greenbrier in White Sulphur Springs in August.—Mrs. Everett H. Starcher, Publicity Chairman.

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The West Virginia Medical Journal

Vol. 61, No. 12 December, 1965

Vagotomy and Pyloroplasty for Duodenal Ulcer*

Raul Vela, M. D.

Vagotomy and pyloroplasty constitute a relatively young surgical procedure. Sufficient experience with its use has been accumulated, however, to establish its safety and reliability in the successful treatment of chronic duodenal ulcer and its complications. There is minimal disturbance of the vital functions of digestion and metabolism, and the surgical mortality and morbidity are low.[32]

The continuing controversy over the preferred operation for the relief of duodenal ulcer indicates the complex nature of the disease.[28]

Smithwick[12] has stated, "The ideal operation for duodenal ulcer is one which always cures the ulcer, prevents its recurrence and leaves the patient asymptomatic." Since at the present time we do not have the operation that fulfills such requirements, we can only choose the one procedure that has been shown to be distinctly superior to all others. In these circumstances, to overcome deficiencies of the gastric resective procedures, "vagotomy and pyloroplasty" has come to occupy a preponderant place for the treatment of this benign disease.[34]

History

Jabulay, in 1892, proposed the use of a distal gastroduodenostomy as a primary method of treatment for duodenal ulcer.[18] Finney,[14] in 1902, first published his method of pyloroplasty by reporting 5 cases and describing the technique of the operation, which remains basically unaltered today.

The anatomicophysiologic studies on "the innervation of the stomach" made by Wertheimer in the early 20's when he wrote his inaugural thesis can be considered the basis for the development of the operation of vagotomy, used by Latarjet and Wertheimer in 1922, with the idea of completely and permanently arresting the cephalic phase of gastric acid secretion.[11-33]

Dragstedt,[6] in 1943, revived the procedure with a more thorough understanding of the physiologic basis as a foundation and with the introduction of a simplified technique of mediastinal vagotomy through the abdominal approach as a part of the operation for chronic duodenal ulceration.

Rationale

Taking into consideration the experimental as well as clinical evidence that the cephalic phase of gastric acid secretion elaborated in excess during the fasting hours is responsible for chronic duodenal ulceration, it is easy to understand the basis on which the operation of vagotomy and pyloroplasty was developed.[7]

Nyhus[28] and his colleagues, working with a small number of dogs, observed that vagus resection and gastrojejunostomy raised the hormonal phase of HCl secretion by about 140 per cent (as evidenced by the secretion in a Hidenhain pouch), whereas, with vagotomy and pyloroplasty the secretion was raised only 16 per cent.

Our goal, then, should be to reduce the acidity to a point below the threshold of ulceration and this can be accomplished only by disconnecting

The Author

- **Raul Vela, M. D., former Resident in Surgery at Charleston General Hospital; now engaged in private practice at Laredo, Texas.**

*Presented before the annual meeting of the West Virginia Chapter, American College of Surgeons, at The Greenbrier in White Sulphur Springs, April 29-May 1, 1965.

Submitted to the Publication Committee, May 5, 1965.

the overactive cephalic stimuli to the stomach (which permits healing of the ulcer with minimal anatomic disturbance), leaving only the antral and intestinal phases to continue the important function of acidification of ingested food.[34]

Besides its favorable action in reducing gastric acidity, vagotomy causes a delay in gastric emptying by diminishing the contractility and tonicity of the gastric musculature. To overcome the effects of gastric inertia, we have to add an emptying procedure which should provide an outlet just large enough to avoid gastric retention without producing too rapid emptying.[15] The Heineke-Mikulicz type of pyloroplasty has been generally accepted because of its simplicity and because it is relatively free of complications.[25]

Indications

The fact that vagotomy and pyloroplasty is less hazardous and less multilating than other procedures does not mean that it should be used more freely in cases in which the indication for surgical treatment is equivocal, because this will aggravate an already difficult situation.[17]

The Lahey Clinic group states that 10 per cent to 12 per cent of patients with duodenal ulcer require operation.

The choice of a surgical procedure frequently is influenced or dictated by the systemic condition of the patient or by unusual local inflammatory or anatomic considerations. One should not hesitate to elect an operation which offers less than maximal protection against the prospect of recurrent ulceration when the risk of performing the optimal operation is an invitation to increased morbidity and mortality.[33]

FIGURE NO. 1 (Continued)

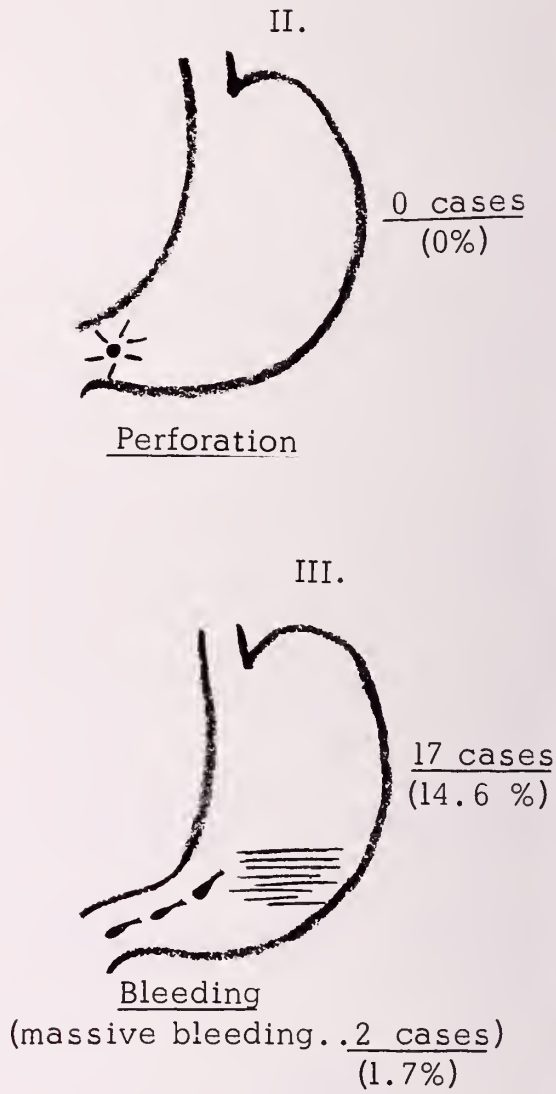


FIGURE NO. 1

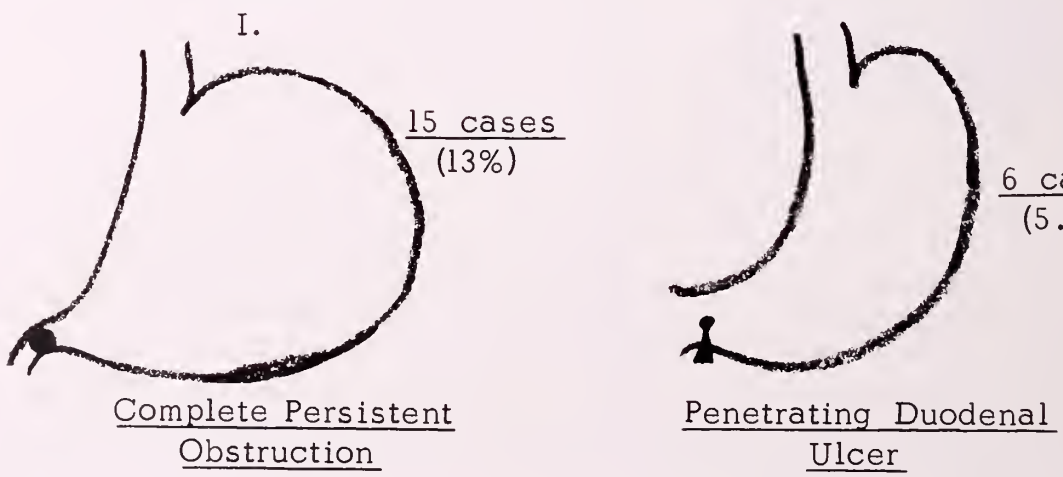
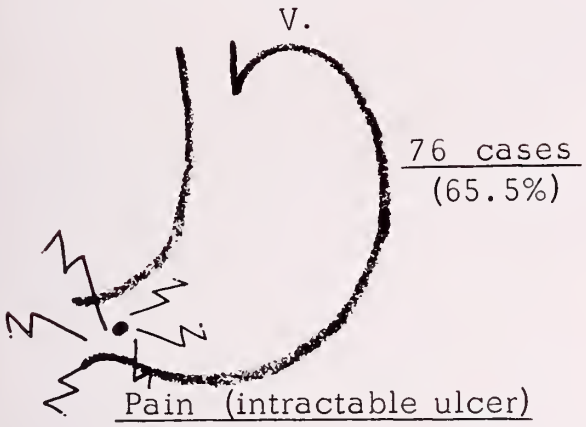


FIGURE NO. 1 (Continued)



Indications for vagotomy and pyloroplasty (Figure 1) are:

(1) Complete persistent obstruction. Use of this surgical procedure in such instances depends upon (a) degree of obstruction; (b) its location (distal duodenal constriction is a definite contraindication to pyloroplasty and (c) degree of fibrosis and distortion at the pyloric outlet (if marked, consideration should be given to gastrojejunostomy or partial gastrectomy).

(2) Perforation. Because of the large number of patients who later need a second operation following closure of the perforation alone, a definitive procedure should be performed at the time of closure of the perforation (if there are no contraindications). When dealing with the acute form of the disease, closure of the perforation will suffice; and this also will be the procedure of choice in elderly debilitated patients with evidence of shock or the patient seen in the hospital more than twelve hours postperforation.[17] In the presence of a perforated chronic duodenal ulcer, the pyloroplasty incision is made across the perforation, no attempt being made to excise the lesion.

(3) Bleeding. Since gastric resection for bleeding duodenal ulcer was abandoned (on adoption of vagotomy, pyloroplasty and ligation), there is a tendency at present to intervene earlier in uncontrolled bleeding.[25]

An operation which may be performed with little risk in an early period may be a hazardous undertaking in later years, and for this reason it is well to regard more than one episode of symptomatic bleeding as an indication for surgical treatment.

(4) Penetrating duodenal ulcer (characterized by intense localized pain penetrating to the back). Following intensive medical therapy, the symptoms tend to recur after the patient resumes his regular activities, but a satisfactory response to vagotomy and pyloroplasty may be anticipated.

(5) Intractability (with poorly defined evidence of ulceration by radiological examination). Although some patients in this category may improve greatly with this operation, in most of these cases the disturbing symptoms may continue as the surgical treatment will have done nothing to relieve the mental aspects of the patient's disturbed condition.[21-20]

Technique

Previous to operation output determination of gastric acid secretion is obtained one or two days preoperatively. A Levin tube is inserted and connected to Wangensteen suction to keep stomach empty of gas and secretions (it will also help during the performance of the vagotomy).[16]

The abdominal cavity is approached through a high transverse or a vertical incision, whichever is preferred.

In order to avoid unnecessary vagotomy, the pyloroduodenal region first should be inspected to support or rule out a diagnosis of possible duodenal ulceration. This may influence the surgeon to perform first the pyloroplasty for direct inspection of the mucosa.

The Vagotomy.—This can be considered the basic feature of the operation.[19] The first step is exposure of the esophageal hiatus. This is accomplished by elevating the left lobe of the liver, bringing the triangular ligament into view. Many surgeons, following the Dragstedt[6] technique,

FIGURE NO. 2

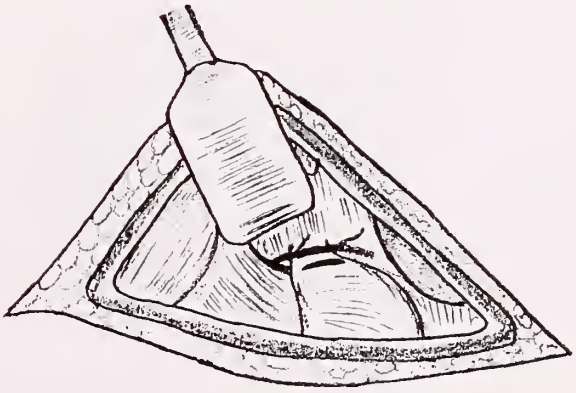


Figure 2. The esophageal hiatal area is exposed by means of a large blade retractor designed for this purpose. The triangular ligament of the left hepatic lobe is left intact. A transverse incision is made in the hiatal membrane for approach to the mediastinum.

prefer to transect the ligament for a better exposure, but bleeding and occasional bile drainage may be troublesome. Through a 1 cm. transverse incision in the hiatal membrane just below the inferior phrenic vessels (Figure 2), the inferior mediastinum is approached by finger dissection, and the terminal portion of the esophagus and vagus nerves is then encircled with a Penrose drain and delivered into the abdomen. Complete division of the nerves is most easily accomplished in the area from 3 to 6 cm. above the esophagogastric junction because this is the level where they are more compact (Figure 3).

A segment of nerve 1 cm. in length should be excised from each nerve trunk for assurance of wide separation of the divided ends because of the remote possibility of regeneration. We should always be sure that no nerve fibers are left intact. The esophagus is then returned to its bed without suturing of the hiatal membrane incision.

Of the total number of 116 cases comprising the series, there was only one which the surgical approach was made through a transverse incision; a longitudinal incision was used in each of the 115 cases remaining. In 80 of the 116 cases the triangular ligament of the left hepatic lobe was divided; in the other 36 cases it was left intact.

The Pyloroplasty.—Although there still are some surgeons who prefer to do a Finney[14] type of procedure, there is general agreement that the Heineke-Mikulicz pyloroplasty is simpler, easier and faster to perform.[33]

After searching for external evidence of ulceration, and being sure that there is no contraction nor distortion of the pyloroduodenal area, the two guide sutures (about 1 cm. apart) are placed on the anterior aspect of the pyloric ring (Figure 4). An incision is made across the ring, extending about 3.5 cm. on the gastric side and 2.5 cm. on the duodenal side (no shorter than 6 and no longer than 8 cm.).

By applying traction at the level of the divided pyloric ring, the pyloroplasty wound is converted from a longitudinal to a transverse direction. Before starting the closure, the distal duodenal part is finger-probed to make sure that there is no obstruction of the lumen.

A one or more layer wound closure (whichever is preferred) is carried out, and some surgeons like to cover the incision with an omental tag to avoid any postoperative adhesions between this area and the liver (Finney and Hoosley).

Postoperative Care.—A nasogastric tube drainage is used for gastric decompression although recently there is a group of surgeons who prefer a gastrostomy tube drainage (Doctor Hendry of

FIGURE NO. 3

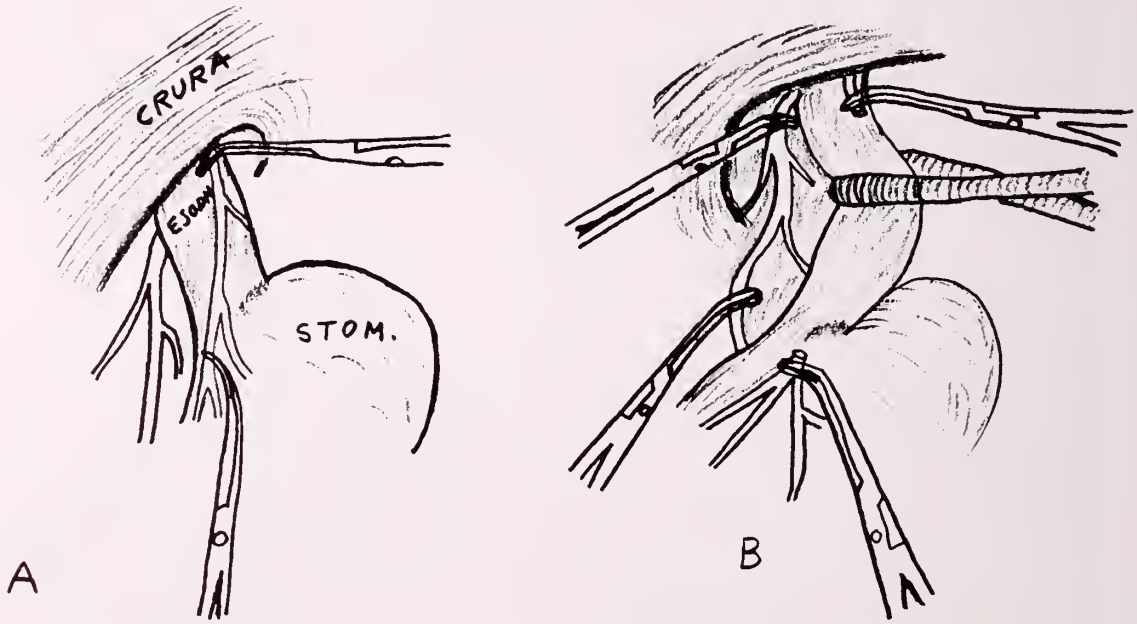


Figure 3. (A) The lower segment of the esophagus has been mobilized and the left vagus nerve has been identified and clamped with right angle ductal forceps. The smaller branches of the nerve are divided and the segment of the nerve between the two clamps is excised. The divided ends of the nerve are ligated with fine silk. (B) The esophagus has been retracted to the left and ventrally by the encircling Penrose drain. This maneuver stretches the right vagus nerve and facilitates its identification. The segment of the nerve between the two clamps is excised. With the esophagus retracted in this fashion it is easy to identify the undivided strands of the nerves which remain.

England), which is removed on the sixth postoperative day.[21] During the first five postoperative days, feeding is limited to appropriate intravenous fluids; on the fifth day, a clear liquid diet is given and, if tolerated, the Levin (or gastrostomy) tube is removed.

Food intake is gradually increased after the sixth postoperative day and advanced to general diet consistent with easily digested nutritious foods, relatively high in proteins, low in fats and starches and without sugar in any form. Alcoholic beverages are excluded.

Clinical Material (Table 1)

During a five-year period, from January, 1960, a total of 116 patients have undergone vagotomy and pyloroplasty as treatment for duodenal ulceration. This group includes both private and service cases operated on by members of the surgical services at the Charleston General Hospital. All patients were treated by subdiaphragmatic vagotomy accompanied by a Heineke-Mikulicz pyloroplasty in 62 cases (53.5 per cent) and by the Finney type of pyloroplasty in 54 cases (46.5 per cent).

The age range was from 19 to 79 years, with an average of about 49 years. The series consisted of 79 male and 37 female patients, with a ratio of 2.1 to 1.

The operation was performed for chronic duodenal ulcer and its complications. Duration of the ulcer-like symptoms ranged up to 32 years, with an average of 15 years. Pain, refractory to medical management, constituted the most common indication for surgical intervention (65.5 per cent).

Bleeding was the principal reason for operation in 17 cases (14.6 per cent). It should be mentioned that the hemorrhage in 2 of the 17 cases was considered massive.

In 15 cases there was pyloric obstruction that required surgical intervention; there were no patients submitted to vagotomy and pyloroplasty for acute perforation of the duodenal ulcer; there were cases in which the patient was operated upon for penetrating duodenal ulcer (5.1 per cent).

Delayed emptying was noted in 2 cases and reoperation was necessary in one case.

Associated chronic debilitating disease such as generalized arteriosclerosis, alcoholism, heart disease, chronic pulmonary disease and hypertension was present in 21 cases, with the highest percentage (47.6 per cent) in the 60 to 69 age group.

Postoperative Follow-Up.—In order to better evaluate our 116 (postoperative) cases, a questionnaire was sent each patient to find out about late complications as well as recurrence rate. One of the 116 cases was considered as a surgical death, and four other patients died of different causes. Of the remaining 111 cases, (Table 2) 61 were found to be completely asymptomatic, and in 50 the patient had one or more postoperative symptoms. Patients in the latter group (symptomatic) were finally reached by telephone or by letter, and brought back to the hospital

FIGURE NO. 4

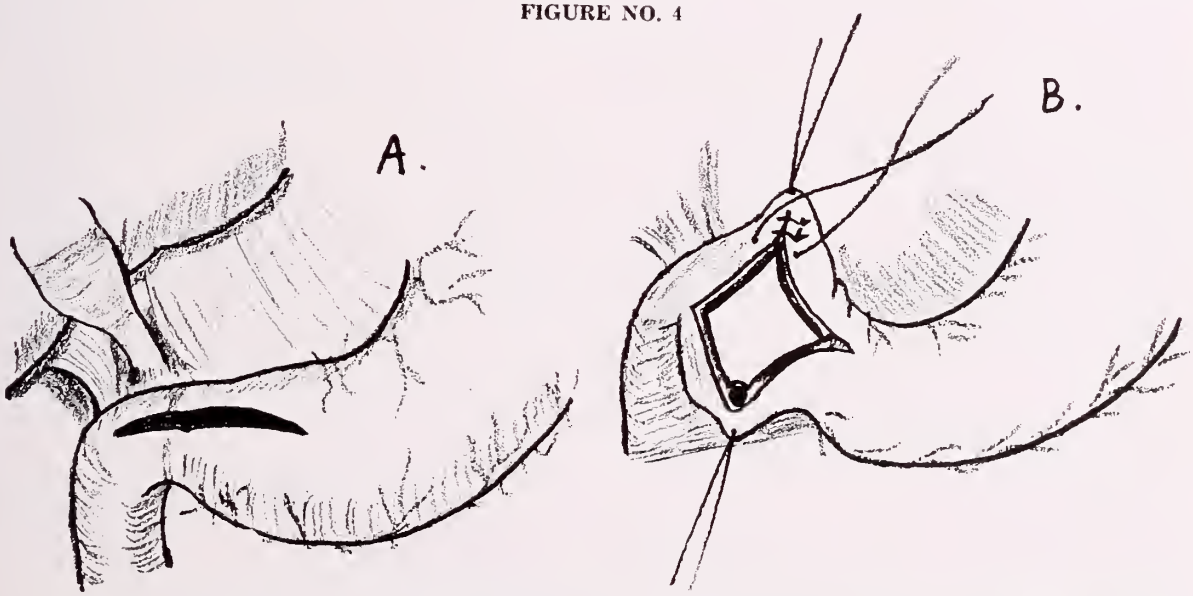


Figure 4. The pyloroplasty. (A) Longitudinal incision is made across the pyloric ring and is then closed in the transverse direction with a single row of sutures which include all layers. (B) Illustrates placement of suture to bring together corresponding layers without eversion.

for gastric analysis. Forty-three of the 50 had a tubeless gastric analysis on an outpatient basis, and the remaining 7 were hospitalized in order to have a tube-gastric analysis because the symptoms were more severe in this particular group of patients.

Of the 43 patients that had the tubeless method, 34 were males and 9 were females. Of the 7 hospitalized patients, five were males and two were females.

Tubeless gastric analysis is a qualitative method; if acid secretion is present by the direct gastric analysis, the tubeless method has been accurate in 95-97 per cent of cases, according to the literature.

Results with the tubeless method (Table 3) were as follows: 22 cases were found to be positive of HCl (51.1 per cent) and the remaining 21 cases (48.8 per cent) gave negative results.

Only 7 patients had the tube-method gastric analysis; in 5 of the 7 cases, the free HCl ranged between 0° and 5°, and between 20° and 28° the total 71.4 per cent.

In the remaining 2 cases (28.5 per cent), the level of acidity ranged between 40° and 50° for the free HCl, and between 56° and 64° for the total, which is sufficient evidence that the vagotomy was incomplete, or that different reasons influenced the level of gastric acidity to remain as high as it probably was before surgery. It would be interesting to mention that one of these 2 cases (the one with the highest level of acidity), had a Hollander's test performed which showed that at the end of 30 minutes the free HCl was 12.6° and only 26° after insulin stimulation.

Results.—These are mainly determined by the effectiveness of the operation in healing the ulcer and curing the disease, by its attending mortality, its morbidity, and late metabolic disturbances.

Recurrence rate should not be taken too deeply into consideration in evaluating the success of a particular operation.

(a) Surgical Mortality (Table 4): There has been one surgical death in the 116 cases treated by vagotomy and pyloroplasty in this hospital, an incidence of 0.8 per cent. For the elective operations alone, there was one surgical death in 114 cases (0.8 per cent). There were no emergency operations for perforated ulcer, and the mortality in emergency operations for massive hemorrhage was zero. Four patients died from different causes, but they were not counted as surgical deaths because they succumbed after the 30th day postdischarge.

(b) Surgical Morbidity—This is considered next in importance (after surgical mortality) in evaluating the success and measuring the merits of this operation (Table 5). Serious complications such as duodenal leakage, injury of common bile duct and traumatic pancreatitis, which are not uncommon with resective procedures, are rare with vagotomy and pyloroplasty.

Complications of vagotomy account for most of the early postoperative morbidity of vagotomy and pyloroplasty.

Table 1

CLINICAL MATERIAL
(Jan. 1960 to Dec. 1964)

Type of Pyloroplasty:	
Heineke-Mikulicz	62 cases (53.5%)
Finney	54 cases (46.5%)
Age Range: From 19 to 79 years (Average 49)	
Sex: 79 Males; 37 Females (Ratio: 2.1 to 1)	
Average Duration of Symptoms: 15 years	
Surgery for Obstruction	15 cases (13%)
Surgery for Perforation	0 (0)
Surgery for Bleeding	17 cases (14.6%)
Surgery for Massive Hemorrhage	2 cases (1.7%)
Surgery for Penetrating Duodenal Ulcer	6 cases (5.1%)
Surgery for Intractible Pain	76 cases (65.5%)
Associated Chronic Debilitating Disease	21 cases (18.1%)

Table 2

Asymptomatic: 61 Symptomatic: 50 (Total: 111 cases)

Tubeless gastric analysis:	
43 cases	
Male	34
Female	9
Tube gastric analysis:	
7 cases	
Male	5
Female	2

Table 3

GASTRIC ANALYSIS RESULTS

Tubeless Method: 43 cases		
Pos. for free HCl		22 (51.1%)
Neg. for free HCl		21 (48.8%)
Tube Method: 7 cases		
Free HCl.	*Total*	
0° to 5°	20° to 28°	5 cases (71.4%)
40° to 50°	56° to 64°	2 cases (28.5%)
(Hollander's Test)		
30 Mins.	*After Histamine*	
12.6°	26°	(1 case)

Table 4

SURGICAL MORTALITY WITH VAGOTOMY AND PYLOROPLASTY

Total Number of operations		116
Total Number of surgical deaths		1 (0.8%)
I.	Elective procedures	114
	Surgical deaths	1
II.	Emergency operations for perforations	0
III.	Emergency operations for massive hemorrhage	2
	Surgical deaths	0

In order to do a more careful study of the complications, it was decided to divide them into two categories (early and late, according to their time in appearance). Of the 116 cases in our series, the most common early complication was splenectomy, which had to be performed in 7 cases due to accidental tear of the splenic capsule during the surgical manipulation. Dumping-like symptoms appeared early in 6 cases; three of the patients became asymptomatic at the end of the two weeks and the other 3 continued to have symptoms and were counted among the 13 cases that had dumping as a late complication. Four patients had early pneumonitis; and in 3 cases, there were frank clinical and radiological signs of atelectasis. Wound infection appeared in 3 cases, but promptly subsided with the administration of broad spectrum antibiotics. In three other cases wound dehiscence developed, but on only one occasion was it necessary to reoperate because of evisceration. Thrombophlebitis appeared in 2 cases which were successfully managed by bed rest, antibiotics and anticoagulants. Postoperative ileus was present in two cases, and only one patient developed postoperative gastric retention which was soon relieved by conservative methods. The only death we had in our series was a 62-year-old man who had a cerebrovascular accident on the first postoperative day and expired three days later.

Among the late complications (which appeared after the patient left the hospital), the one heading the list is diarrhea (5 or more bowel movements daily), which appeared in 29 cases; in 20 instances, it was considered mild, but 9 patients described the symptom as severe. The onset of this complication ranged between two weeks and one year postsurgery. The interesting thing is that it lasted only about three months in 60 per cent of the cases; of the remaining 40 per cent half of them had it for a period of eight to ten months and then it progressively disappeared; the other half (or 20 per cent of the 29 cases) still have it, off and on, two years later, with a tendency to become a mild symptom. Dysphagia was the next complication in the list, with 21 cases; 15 patients had this symptom for only 4 to 5 weeks postdischarge; 3 experienced it for 3 months, and the remaining 3 still have it occasionally, between 6 months and 1 year postsurgery.

Weight loss was a late complication in 20 cases (17.2 per cent), which ranged between 20 and 50 pounds; 12 state that they gained their weight back within 1 year; four had to wait two years in order to reach their normal weight;

Table 5

(VAGOTOMY AND PYLOROPLASTY: 116 Cases) COMPLICATIONS

EARLY	No. Cases	Incidence	LATE	No. Cases	Incidence
Atelectasis	3	2.5%	Bloating	17	14.6%
C. V. A.	1	0.8%	Diarrhea: Mild	20	17.2%
"Dumping"	6	5.1%	Severe	9	7.7%
Evisceration	1	0.8%	Dumping	13	11.2%
Gastric retention	1	0.8%	Dysphagia	21	18.1%
Ileus	2	1.7%	Pancreatitis	1	0.8%
Pneumonitis	4	3.4%	Rectal bleeding	4	3.4%
Persistent ulcer	2	1.7%	Recurrent ulcer	7	6%
Splenectomy	7	6%	Subphrenic abscess	2	1.7%
Thrombophlebitis (leg)	2	1.7%	Ulcer-like pain	16	13%
Wound infection	3	2.5%	Vomiting	14	12%
Wound dehiscence	3	2.5%	Weight loss	20	17.2%

Table 6

RECURRENCE (Based on 116 Cases)

Postoperative (Years)	No. of Cases	Incidence	Sex
1	8	6.9%	Male: 4 (3.4%)
2	1	0.8%	Female: 4 (3.4%)
3	0		Male: 1 (0.8%)
4	0		Female: 0
5	0		

TABLE 7

TYPE OF RECURRENCE

	I	*II*	*III*
Males	0 (–%)	3 (2.5%)	2 (1.7%)
Females	2 (1.7%)	1 (0.8%)	1 (0.8%)

Table 8

INDICATIONS FOR PREVIOUS SURGERY

Indication	*No. of Cases*	*Incidence*
Intractability	7	6%
Bleeding	2	1.7%
Perforation	0	
Obstruction	0	
Massive hemorrhage	0	

Table 9

MANAGEMENT OF RECURRENCES

	No. of Cases	*Incidence*
Medical	3	2.5%
Bilroth I	1	0.8%
Bilroth II	4	3.4%
Antrectomy	1	0.8%

Table 10

OVER-ALL RESULTS

(Exclusive of Surgical Mortality)

Based on 116 consecutive cases with follow-up.

		At the end of	Cases	%
Excellent: 77 cases (67%)	Asymptomatic	3 years	74	(64.3%)
		5 years	3	(2.6%)
Satisfactory: 29 cases (25.2%)	Improved	3 years	25	(21.7%)
		5 years	4	(3.4%)
Poor: 9 cases (7.8%)	Worse		4	(3.4%)
	Unimproved		5	(4.3%)

(4 cases died from different causes and not counted as surgical deaths.)

the remaining four still are underweight, between five months and three years after surgery.

Postprandial bloating was a late complication in 17 cases, but persists in only 6, off and on, one year after surgery.

Ulcer-like pain was present as a late complication in 16 cases (13 per cent) of which 10 patients still complain of it 18 months after surgery.

Vomiting has been an inconstant symptom in 14 cases (12 per cent). In 6, it was present for only 3 months; in 4 it lasted about 1 year; the remaining 4 are considered too nervous and apprehensive to evaluate this symptom correctly.

Dumping syndrome appeared in 13 instances as a late complication (in 3 cases it appeared early as previously stated); 4 patients still have it off and on, 15 to 24 months later.

Rectal bleeding has been present sporadically in 4 cases (up to two and a half years postsurgery). In 2 instances, a subphrenic abscess had to be drained, and in only 1 case did a picture of pancreatitis develop as a late complication.

(c) Recurrence: Its determination is often difficult, and sometimes impossible because of the unreliability of objective and subjective evidence. Postoperative bleeding should not be considered as evidence of recurrence, because it might come from a different source. Even from the radiological standpoint, there exists the possibility of error in interpretation, because of the marked duodenal deformity that appears after a pyloroplasty procedure. As recurrence, we considered the following: Type I: Persistent postoperative ulceration; Type II: Recurrence of ulceration after a symptom-free interval; Type III: Formation of an ulcer at a different site (Table 6).

In our group of 116 cases in which the patients were observed for five years (followed by interview or "questionnaire"), there were proved or suspected recurrences in 9 cases or a recurrence of 7.7 per cent (6.9 per cent in the first year postoperative cases and 0.8 per cent in the group of patients on their second postoperative year).

The Type I recurrence (Table 7) was found in 2 cases (1.7 per cent), of which none were males, two were females. The Type II recurrence appeared in 3 male patients and 1 female; 3 patients had the Type III recurrence (1.7 per cent males, 0.8 per cent females).

Of 9 recurrent cases in our group (Table 8), 7 patients, or 6 per cent, had been operated on for intractability and 2 for bleeding. There were no recurrences among the patients previously operated on to relieve obstruction or to stop massive hemorrhage. Of the 9 recurrences (Table 9), 3, or 2.5 per cent, were managed by medical means and the rest (6 patients) were managed surgically, one of these by undergoing a Bilroth I (later, this patient had to have a Bilroth II type of procedure elsewhere), 1 case (0.8 per cent) by antrectomy, and 4 cases by Bilroth II.

The over-all results (Table 10) exclusive of surgical mortality (based on 116 consecutive cases with follow-up for five years), can be considered as excellent in 77 cases (67 per cent), satisfactory in 29 cases (25.2 per cent) and poor in 9 cases (7.8 per cent).

Summary

Experience with 116 cases of vagotomy and pyloroplasty over the past five years at the Charleston General Hospital shows the method to be a useful procedure for the surgical treatment of the chronic duodenal ulcer.

The special advantages of the combined procedure over procedures involving partial gastric resection or gastrojejunostomy are its low surgical mortality and morbidity, and the minimal disturbance of the integrity of the digestive function.

The operation is reliable and has produced healing in 92 per cent of cases in which it was used in this hospital.

A list of references may be obtained by writing to The Journal.

A friend is someone you don't have to be nice to.

ARNOLD H. GLASCOW.

The Choice in Breech Delivery*

Philip P. Steptoe, M. D.

The past twenty years have seen a remarkable drop in maternal mortality rates in our country, to a degree that one even hears the phrase "irreducible minimum." Paralleling this improvement in obstetrical care and, indeed, playing a large part in it, has been the increasing safety of the Caesarean section operation for delivery. These two accomplishments in obstetrical progress have formed the basis for a shift of some of the emphasis on obstetrical care to the fetus. With the safety of the mother assured we can afford to be more radical for the sake of the baby, and Caesarean section often is the means by which this is done.

A Hazard to the Baby

In common with many other phases of obstetrics these developments have had their effect on the handling of breech presentation. It is well known that breech delivery carries with it an increased hazard to the baby; mortality figures suggest this to be on the order of 2½ times that of normal vertex delivery. We have no really valid statistics as to birth injuries which are not fatal but leave a handicapped child. It is freely conceded, however, that breech delivery is responsible for an increased perinatal morbidity.

A discussion of Caesarean section versus vaginal delivery of the breech baby must revolve around two basic questions:

1. To what extent can Caesarean section delivery improve the chances of getting a living and healthy baby, and at what cost to the mother?
2. What part of the breech perinatal mortality and morbidity is due to obstetrical complications rather than to the presentation itself and the mechanics of vaginal delivery?

First, let us examine the record of Caesarean section as of recent years. For the mother it may be a very safe operation indeed. An elective section, that is, one performed on the surgical schedule with proper preparation, runs a risk of maternal mortality of less than ½ of 1 per cent and a fetal mortality rate which, for term infants, approaches that of normal vertex delivery. Comparison of these figures with those of vaginal delivery has led a few obstetricians to adopt a radical policy of doing sections on all breech presentations at term, or in all primigravidous breech cases at term, or in those which have come to labor. Their example can be criticized, however, by some of the following considerations:

(1) A certain number of sections for this indication will be done not under ideal elective conditions, but in the case of a patient already in labor, often with a full stomach, sometimes with ruptured membranes or bleeding, presenting herself as an emergency after a hurried trip to the hospital. This is the pattern of one of the largest categories of maternal mortality in present day obstetrics.

(2) Alternatively, the obstetrician may decide to section the patient before labor or near term, which involves the risk of overestimating the size and maturity of the fetus and the possibility of delivering a premature baby. Not only in these instances but even in the near-term pregnancies such a policy will result in a certain number of unnecessary operations, for some of these babies would turn before the onset of labor or with the first few pains.

(3) Whenever a first Caesarean section is under consideration we ought to give a few minutes' thought to the long range consequences. "Once a Caesarean, always a Caesarean" is the dictum generally followed over the country. Even if you do not believe in this, or modify it for individual cases, you must admit the reason behind it: the danger of rupture of the uterine scar during labor. Whichever way we choose to deliver this patient in a subsequent pregnancy, she is exposed to a greater hazard. On the one hand, there is the danger of uterine rupture during labor. On the other hand, there are the risks of repeat operation with accompanying

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***Presented before the 9th annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 23-25, 1964.**

Submitted to the Publication Committee, May 12, 1965.

anesthetic and postoperative problems, and an attendant risk to the baby, as outlined above.

(4) Finally, in any surgical procedure there are drawbacks which do not show up in the mortality statistics and which go beyond the discomfort of the recovery period. These include anesthetic complications, increased blood loss, transfusion risk, wound infection and the occasional but frightening instance of postoperative ileus.

I don't think it can be argued convincingly that Caesarean section is as safe for the mother as vaginal delivery. It can be stated that it is safer for the baby when unfavorable factors complicate the delivery. The pertinent question now to be considered is whether breech delivery, otherwise uncomplicated, is sufficiently hazardous to the fetus to justify routine Caesarean section. One can answer this only by the indirect method: A great many breech babies are delivered vaginally without incident and apparently in good condition. For example, Wolter et al remark that they would have had to section 252 women unnecessarily to save 3 breech babies which they lost by vaginal delivery. More to the point is that analysis of those fetal and neonatal losses which do occur almost always brings to light unrecognized complicating factors or faulty technique of delivery.

Cord Prolapse

If there is a fetal hazard inherent in the breech delivery, it is that of cord prolapse. It is not generally realized that the frank breech at term is no more liable to this accident than is the term vertex presentation. The other 40 per cent of term breech presentations are footling or complete, and in these cases cord prolapse is a calculated risk of vaginal delivery. Whether such situations are of themselves sufficient indication for abdominal delivery is a question to be answered by the individual physician, and in my view no criticism attaches to a decision either way. If prolapse should occur during labor at the hospital, the pressure may be taken off the cord by the knee-chest position, and an emergency Caesarean section usually will produce a healthy baby. Such conservative handling calls for careful observation of the patient in labor, frequent vaginal examination, and preparations for Caesarean section on a stand-by basis.

If the uncomplicated breech may be delivered vaginally with very little risk, it becomes the more important to recognize complicated cases. It may be helpful to classify these somewhat as follows:

(1) Those obstetric problems which of themselves would indicate a Caesarean section, or at least serious consideration of it. Examples of this lie with placenta previa, diabetes, toxemia, myomata with possible obstruction, and previous Caesarean section.

(2) All reports agree that even relative disproportion seriously affects the chances of the fetus. The after-coming head cannot adjust itself in a matter of seconds or minutes to a birth canal which is not entirely adequate. The corollary to be drawn here is that x-ray pelvimetry is mandatory whenever a primagravida presents by breech in the last month, and likewise for those multiparae whose pelves are suspect.

(3) The oversize baby carries an increased risk in pelvic delivery, sometimes by reason of relative disproportion, sometimes because of inertial labor, and often in terms of mechanical and technical difficulties caused by size alone.

(4) The "premium" baby should have the benefit of delivery by Caesarean section. The woman with the long history of infertility, the elderly primigravida, the woman with the poor obstetric history is willing to accept the increased risk to herself, and probably will experience less exposure to the risks of the future.

(5) The uterine inertia case should come to section a little sooner when she is contending with a breech presentation. Given a patient in unquestioned labor for ten to twelve hours without recent progress and without delivery in prospect, the best interests of the baby and probably of the mother too will be served by abdominal delivery. This is a good place to bring up the question of oxytocic stimulation of labor. Reports in the literature generally indicate a very cautious attitude toward this procedure and express doubt that it is of value. One suspects that the failures are due not so much to the fact that we are dealing with a breech presentation as to the stage in labor at which it is employed. It is well known that the oxytocics have limited effect after inertia has set in. Logically, one comes back to the general principle that the uncomplicated breech can be delivered vaginally, the complicated one should be sectioned. If uterine inertia has developed, we are already dealing with a complicated case and one in which the fetus already is at risk.

Earlier in this paper, it was stated that analyses of fetal and neonatal deaths connected with breech delivery indicated faulty operative technique as the other basic cause. There is no place in this paper to review the technique of vaginal delivery, but only to state that in this

matter proficiency follows experience. There is no better indication for a consultant and well qualified assistant to be scrubbed and at your elbow than during this delivery. Finally, there may well be situations in which the more prudent course in your hands is section delivery, even though the case is capable of being delivered from below by someone else.

Premature Breech Labor Complications

This paper has dealt primarily with the problem of the term breech delivery. Premature breech labors are complicated. They are complicated by the fragility of the premature baby; they are complicated by footling position in the majority of cases, and by frequent prolapse of the cord; they are complicated by intrapartum infection which inevitably follows premature rupture of membranes with delayed labor; they are complicated by that pathology of pregnancy which is responsible for the onset of premature labor in the first place; finally, premature infants are notoriously susceptible to hyaline membrane disease and although Caesarean section is generally thought to increase this susceptibility, it is not certain that this differential holds over breech delivery by vagina. Enough has been said to make it clear why no general rules can be drawn for this group of cases. The obstetrician often is faced with an emergency and must meet it the best way he can. Even when he has time to deliberate, he is not likely to discover distinctly better odds with one form of delivery over the other. He is justified in making his decisions on an individual basis and must be reconciled to poor results either way. On occasion he must make the distressing judgment that the chances of a very premature baby do not warrant the disadvantages of Caesarean section to the mother.

Summary

In summary, the trend to Caesarean section delivery of the complicated term breech pregnancy is well based on past experience, but the routine use of this operation for all term breech presentations does not seem to promise enough fetal salvage to offset the disadvantages of this major surgical procedure. It is possible that our views on this point will change if long range studies of morbidity indicate that vaginal delivery of the uncomplicated breech is accompanied by a considerable number of birth injuries which are not being recognized at birth. For the time being our efforts are better directed toward recognizing the complicated case and toward perfecting the technique of vaginal breech delivery. The prematures are in a special category for which no general rules can be drawn and in which treatment should be individualized.

References

1. Bulfin, M. J. & Gallagher, J. T.: The Primipara With Breech Presentation, Obst. & Gynec. 16:283, 1960.
2. Hall, J. E. & Kohl, S.: Breech Presentation, Am. J. Obst. & Gynec. 72:977, 1956.
3. Morgan, H. S.: Management of Breech Presentation, Clin. Obst. & Gynec. 5:1009, 1962.
4. Potter, M. G., Jr., Heaton, C. E. & Douglas, G. W.: Intrinsic Fetal Risk in Breech Delivery, Obst. & Gynec. 15:158, 1960.
5. Wright, R. C.: Reduction of Perinatal Mortality and Morbidity in Breech Delivery Through Routine Use of Cesarean Section, Obst. & Gynec. 14:758, 1959.

USP and 'Generic Equivalence'

There are many facts about the so-called "generic equivalent" drugs which have an important bearing on the effect of the drug on the patient and the physician's security in prescribing them. There is adequate evidence that generic name drugs are not necessarily equivalent to each other. The label "USP" means that the manufacturer is claiming to meet minimum standards. It does not necessarily mean that he has been proven to have obtained those standards. Not all drug manufacturing techniques and equipment are so well standardized that the products are of uniform quality. The tendency of a manufacturer of a generic drug is to meet minimal and not optimal standards.—Editorial in Journal of the Louisiana State Medical Society.

The Effect of the Chronic Administration of Reserpine On the Responses to Sympathomimetic Amines*

William W. Fleming, Ph. D.

One of the pharmacological characteristics of Rauwolfia alkaloids is the ability to alter the sensitivity both of animals and man to sympathomimetic amines. This review will be limited to reserpine (Serpasil) since most of the research on this subject has been done with that substance. It is evident, however, that extracts of Rauwolfia (Rauwiloid)[1] and syrosingopine (Singoserp)[2] have similar actions.

Reserpine causes depletion of norepinephrine from all peripheral tissues.[3] The normal tissue content of norepinephrine is located in the endings of sympathetic nerves which innervate the tissue.[3] Depletion of norepinephrine from peripheral tissue thus signifies a loss of this neurotransmitter from the sympathetic nerves. Without the transmitter, the sympathetic nerves, although still carrying impulses, cannot exert an effect on the cardiac muscle and smooth muscle which they innervate. The dose of reserpine required to produce depletion of norepinephrine varies with the duration of treatment,[4] the individual organ[5] and the species.[6] It has been definitely established that the norepinephrine content of the heart is severely depleted in man under the standard antihypertensive therapy with reserpine.[7] It is the loss of the physiological source of norepinephrine that is responsible for the altered sensitivity of the tissue to sympathomimetic amines.[8, 9]

Quantitative changes in the sensitivity to drugs can best be studied if full dose-response curves for the drugs are determined.[8] Much research has been done using laboratory animals in the study of the effects of reserpine, while very few such experiments have been performed in humans, especially using dose-response curves. I shall discuss this phenomenon, therefore, from the standpoint of animal experiments. There is adequate material in the literature, however, to suggest that the conclusions drawn are relevant to man also.[10, 11]

*Presented before the 9th annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 23-25, 1964.

Submitted to the Publication Committee, May 12, 1965.

The Author

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Three Groups of Sympathomimetics

Sympathomimetics have been subdivided into three groups.[8] The first group may be called direct-acting and includes norepinephrine (levarterenol, Levophed) and epinephrine (Adrenalin). The prototype of the second group, the indirect-acting amines, is tyramine. Ephedrine is an example of the third group which includes those amines whose action is partly direct and partly indirect. The meanings of this classification are demonstrated diagrammatically in Figure 1. Direct-acting amines such as epinephrine act on the responding cells themselves (Figure 1-a) and do not require the presence of the sympathetic nerves to produce a response. Indirect-acting amines such as tyramine have no effect on the responding cells. Instead, they act on the sympathetic nerve endings to cause the release of norepinephrine (NE) from its physiological store (Figure 1-b). It is this released norepinephrine which produces the actual response of the effector cells. Ephedrine (Figure 1-c) has some direct action on the effector and causes some release of norepinephrine from the nerve ending.

Chronic treatment with reserpine affects sensitivity to these three groups of amines in different ways.[8] Sensitivity to direct-acting amines is increased. By this is meant that in the reserpinized animal a given response occurs with a smaller dose of the amine than in the untreated animal. The maximal response attained is not altered; it merely occurs with an unusually small dose. This supersensitivity apparently is due to some physiological change in the responding cells so that their irritability to pharmacological stimuli is enhanced.[9]

Response to an indirect-acting sympathomimetic is depressed by treatment with reserpine

and, with proper dosage, is virtually abolished.[12] The maximal response no longer is obtainable with any dose. This is not surprising, since reserpine depletes norepinephrine from sympathetic nerve endings and indirect-acting amines are dependent upon this physiological source of norepinephrine.

The responses to substances (such as ephedrine) which act partly on the effector cells and partly through release of endogenous norepinephrine are altered in still a different manner by chronic treatment with reserpine. Sensitivity to these agents either is unchanged or only moderately decreased and the maximal response attainable is not decreased.[8] A maximal response can be obtained by increasing the dose. With such an amine, loss of indirect activity (due to the lack of endogenous norepinephrine) is partly compensated for by increased sensitivity of the responding cells to the direct component of activity.

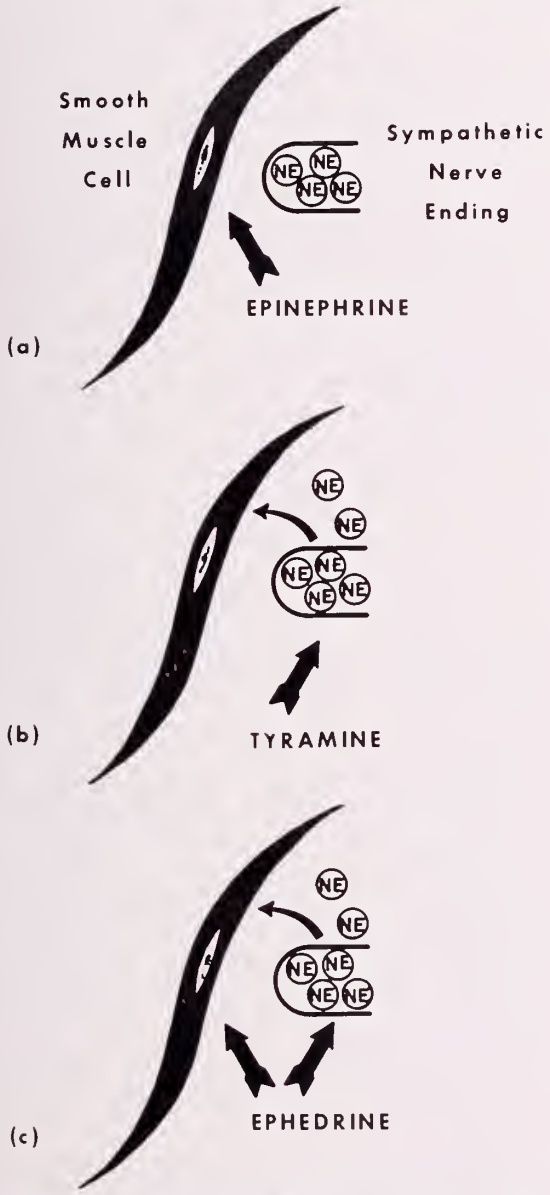

Figure 1. Diagrammatic illustration of action of the three types of sympathomimetic amines. Epinephrine acts directly on the effector cells. Tyramine acts on the sympathetic nerve ending to cause release of physiologically stored norepinephrine (NE). Ephedrine has a combination of both of these actions.

Recent work has indicated that this classification of sympathomimetic amines can be correlated with specific aspects of the chemical structure of the amines. Figure 2-g presents the structure which is basic to most sympathomimetic amines. The substance illustrated is phenylethylamine, an indirect-acting sympathomimetic.[13] As an indirect-acting amine, its action is lost when the physiological stores of norepinephrine are depleted by reserpine. If, however, hydroxyl groups are added at the meta position of the ring and the beta position of the side chain, the amine becomes a direct-acting sympathomimetic and sensitivity to it will be increased by chronic reserpine treatment.[13, 14] The importance of the hydroxyl groups is indicated by the fact that other groups such as methoxy and keto do not greatly increase direct activity when substituted at the meta and beta positions.[13] Substitutions on the terminal nitrogen or the alpha carbon, although altering the potency and other aspects of pharmacological activity, do not significantly affect the direct and indirect activity.[13] These generalizations can be applied to some of the clinically used sympathomimetics. The structures illustrated in Figure 2 can be taken as examples.

Norepinephrine (Levophed), epinephrine (Adrenalin), phenylephrine (NeoSynephrin) and isoproterenol (Isuprel) all possess both the meta and the beta groups and thus are direct-acting sympathomimetics. Chronic treatment with reserpine increases sensitivity to all four.[8] Ephedrine possesses the beta hydroxyl but not the meta and thus is an amine of mixed action.[8] Although reserpine pretreatment does not greatly change the sensitivity of some responses to ephedrine,[15] response of the vascular system to ephedrine is depressed.[16] Good pressor responses, nevertheless, can be obtained in reserpinized animals by using larger doses of ephedrine.[14] Methoxamine (Vasoxyl) has been included in only one quantitative study,[13] in which it was found to be similar to ephedrine.[15] Like ephedrine, methoxamine possesses the beta hydroxyl group but not the meta. Amphetamine and mephentermine (Wyamine) have neither the meta nor the beta hydroxyl group and, therefore, are indirect-acting amines.[8] They are

virtually inactive following depletion of norepinephrine by reserpine.

This knowledge has some distinct implications in the clinical use of sympathomimetics. Reserpine lowers the threshold of the heart to arrhythmia induced by norepinephrine and epinephrine in the cat.[17] Such enhancement of toxicity should be watched for carefully when norepinephrine, epinephrine, phenylephrine or isoproterenol is administered, to determine whether or not this occurs in man. Sensitivity may be increased to any effect, therapeutic or toxic, of the direct acting sympathomimetics.

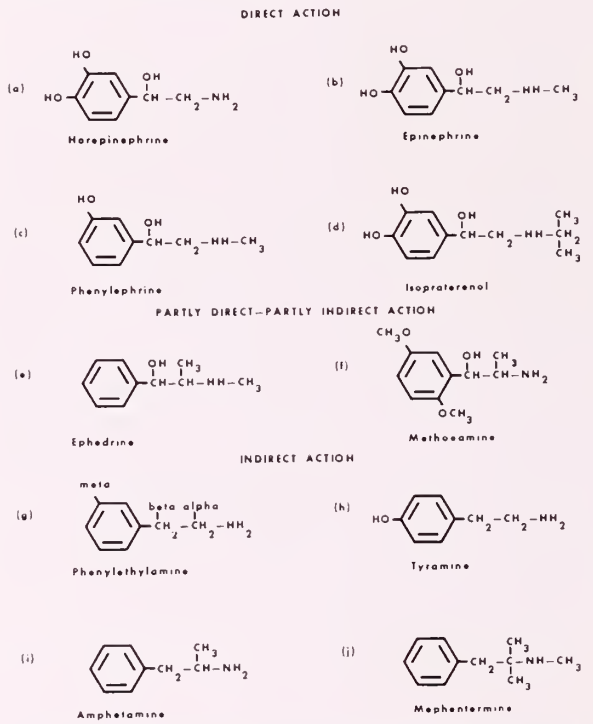

Figure 2. Chemical structure of sympathomimetic amines in relation to their type of action. Phenylethylamine, which has no substitutions, is used to illustrate the terminology of the molecular sites at which important differences occur.

Since reserpine therapy does result in impairment of sympathetic activity, there may be a greater tendency among patients on such therapy to become hypotensive. Such certainly seems to be the case during anesthesia with thiopental (Pentothal).[18] Thiopental has a depressant effect on the myocardium which is normally counteracted by sympathetic activity. By depleting the sympathetic nervous system of its neurotransmitter, reserpine unmasks this cardiac depressing effect of the barbiturate.[19] Normally, one choice for overcoming hypotension resulting from cardiac depression would be mephentermine. Since, however, it is an indirect-acting sympathomimetic, it would be ineffective in a patient on reserpine therapy. One might use an amine of mixed action, such as ephedrine or methoxamine, but it would be necessary to use a larger than usual dose. The best choice probably would be an infusion of norepinephrine, bearing in mind that smaller than usual infusion rates may be called for and being alert to early signs of cardiac arrhythmias.

Rauwolfia alkaloids are not the only antihypertensives which produce the above effects on sensitivity to sympathomimetics. Guanethidine (Ismelin), although pharmacologically quite different from reserpine in some respects, also depletes norepinephrine from sympathetic nerves[20, 21] and causes similar changes in sensitivity to sympathomimetic amines.[22, 23] Thus, the same problems should be kept in mind when administering sympathomimetic amines to patients on guanethidine therapy.

Summary

Reserpine and other Rauwolfia alkaloids cause depletion of the sympathetic neurotransmitter, norepinephrine. As a consequence, the action of such sympathomimetics as amphetamine and mephentermine (Wyamine) which produce their effects by the release of physiological stores of norepinephrine, is virtually abolished. An increase in sensitivity (supersensitivity) to such sympathomimetics as norepinephrine (Levophed) and epinephrine (Adrenalin), which act directly on the responding cells without releasing endogenous norepinephrine, occurs under the same conditions. These sensitivity changes and some of their possible consequences are discussed in terms of the structure—activity relationships among sympathomimetics.

References

1. Gourzis, J., Sonnenschein, R. & Barden, R.: Alterations in Cardiovascular Responses of the Dog Following Rauwiloid, an Alkaloidal Extract of Rauwolfia serpentina, J. Pharmacol. 110:21, 1954.
2. Orlans, F. B. H., Finger, K. F. & Brodie, B. B.: Pharmacological Consequences of the Selective Release of Peripheral Norepinephrine by Syrosingopine (SU3118), J. Pharmacol. 128:131, 1960.
3. Weiner, N.: The Catecholamines: Biosynthesis, Storage and Release, Metabolism and Metabolic Effects in the Hormones, Vol. IV. Ed. Pincus, G., Thimann, K. V. & Astwood, E. B., Academic Press, New York, 1964.
4. Fleming, W. W. & Trendelenburg, U.: Development of Supersensitivity to Norepinephrine after Pretreatment with Reserpine, J. Pharmacol. 133:41, 1961.
5. Trendelenburg, U. & Weiner, N.: Sensitivity of the Nictitating Membrane after Various Procedures and Agents, J. Pharmacol. 136:152, 1962.
6. Paasonen, M. K. & Krayer, O.: Release of Norepinephrine from the Mammalian Heart by Reserpine, J. Pharmacol. 123:153, 1958.

7. Chidsey, C. A., Braunwald, E., Morrow, A. G., & Mason, D. T.: Myocardial Norepinephrine Concentration in Man, New England J. Med. 269:653, 1963.
8. Trendelenburg, U.: Supersensitivity and Subsensitivity to Sympathomimetic Amines, Pharmacol. Rev. 15:225, 1963.
9. Fleming, W. W.: A Comparative Study of Supersensitivity to Norepinephrine and Acetylcholine Produced by Denervation, Decentralization and Reserpine, J. Pharmacol. 141:173, 1963.
10. Mahon, W. A. & Mashford, M. L.: The Pressor Effect of Tyramine in Man and Its Modification by Reserpine Pretreatment, J. Clin. Investigation 42:338, 1963.
11. Abboud, F. M. & Eckstein, J. W.: Effects of Small Oral Doses of Reserpine on Vascular Responses to Tyramine and Norepinephrine in Man, Circulation 29:219, 1964.
12. Trendelenburg, U.: Modification of the Effect of Tyramine by Various Agents and Procedures, J. Pharmacol. 134:8, 1961.
13. Schmidt, J. L. & Fleming, W. W.: The Structure of Sympathomimetics as Related to Reserpine Induced Sensitivity Changes in the Rabbit Ileum, J. Pharmacol. 139:230, 1963.
14. Trendelenburg, U., Muskus, A., Fleming, W. W. & Gomez Alonso de la Sierra, B.: Modification by Reserpine of the Action of Sympathomimetic Amines in Spinal Cats; A Classification of Sympathomimetic Amines, J. Pharmacol. 138:170, 1962.
15. Fleming, W. W. & Schmidt, J. L.: Sensitivity of the Isolated Rabbit Ileum to Sympathomimetic Amines Following Reserpine Pretreatment, J. Pharmacol. 135:34, 1962.
16. Burn, J. H. & Rand, M. J.: The Action of Sympathomimetic Amines in Animals Treated with Reserpine, J. Physiol. 144:314, 1958.
17. Fleming, W. W.: Supersensitivity of the Cat Heart to Catecholamine Induced Arrhythmias Following Reserpine Pretreatment, Proc. Soc. Exper. Biol. & Med. 111:484, 1962.
18. Coakley, C. S., Alpert, S. & Boling, J. S.: Circulatory Responses During Anesthesia of Patients on Rauwolfia Therapy, J. A. M. A. 161:1143, 1956.
19. Stump, J. M. & Fleming, W. W.: Effect of Reserpine Pretreatment on the Hypotensive Action of Thiopental, Arch. f. exper. Path. u. Pharmakol. 248:166, 1964.
20. Cass R., Kuntzman, R. & Brodie, B. B.: Norepinephrine Depletion as a Possible Mechanism of Action of Guanethidine (SU5864), a New Hypotensive Agent, Proc. Soc. exper. Biol. & Med. 103:871, 1960.
21. Cass, R. & Spriggs, T. L. B.: Tissue Amine Levels and Sympathetic Blockade after Guanethidine and Bretylium, Brit. J. Pharmacol. 17:442, 1961.
22. Maxwell, R. A., Plummer, A. J., Povalski, H. & Schneider, F.: Concerning a Possible Action of Guanethidine in Smooth Muscle, J. Pharmacol. 129:24, 1960.
23. Boura, A. L. A. & Green, A. F.: Comparison of Bretylium and Guanethidine: Tolerance, and Effects on Adrenergic Nerve Function and Responses to Sympathominetic Amines, Brit. J. Pharmacol. 19:13, 1962.

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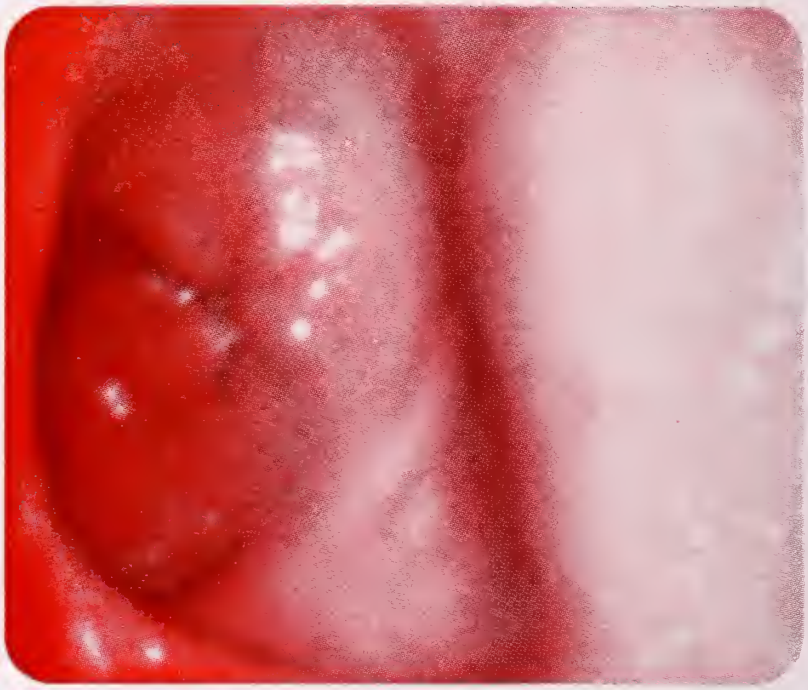

A/ E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

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1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

Research in the Service of Medicine

The President's Page

NOW YOU'RE TALKING

In the September issue of *The West Virginia Medical Journal*, I introduced Plan CO-CO—Cooperation and Communication. And I further stated if there is to be effective communication there must be bilateral comprehension. As I have had the pleasure and beneficial experience of visiting 12 of our county medical societies and of participating in workshop studies with your officers and members, I feel that our understanding of each other's problems has been immeasurably improved. But at the same time I feel that we have only initiated this process of communication. We have mainly determined how ineffective we have been in the past, and although many formats and media have been utilized, there is no technique that will replace the individual face-to-face interchange of attitudes and information. The above approach, although desirable, is impractical in an organization of our size and geographical distribution, but one of our guiding principles to facilitate the interchange of information should be to hold our discussions with the smallest groups consistent with time factors.

To further our cooperation and communication, the Council has approved the organization of a County Medical Society Officers Workshop to be held in Charleston in late February. At this time the duties and responsibilities of county officers can be discussed by the men most concerned and also the most knowledgeable—the county officers themselves. As certain differences are apparent between the various county societies depending on their size, the workshops can be conducted on this basis to permit freer communication and discussion. The steering committee of this conference would appreciate your recommendations of subjects you wish discussed.

It is a further recommendation of the Council to further our communications that the Council member from your district be asked to report to your society after each meeting of the Council. To formalize this procedure, a motion was passed at the meeting of the Council and will be transmitted to the secretary and president of each county medical society.

Another failure of communication which has become evident is with our medical students at the Medical Center in Morgantown. Dean Clark K. Sleeth has offered to furnish each county medical society with a list of those students from their respective counties who are now students at the Medical Center. It will then become the responsibility of each county medical society and its members to maintain effective contact and communication with these students. It was the feeling of some of these students that we do not need nor want them to practice in West Virginia. This serious error of communication must be overcome.

Various surveys and studies are under way to better inform us of the problems and complexities of county medical societies. As this information becomes available, it will be disseminated for your better understanding. Individual communication from our members is requested and will be most valuable to our general understanding.

LET'S TALK TOGETHER—LET'S WORK TOGETHER—LET'S SERVE TOGETHER.

Seigle W. Parks, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

Official Organ of the West Virginia State Medical Association

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author or communicant shall be held entirely responsible.

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Published monthly on the first day of the month, at Charleston, by the West Virginia State Medical Association. Original articles are accepted on condition that they are contributed exclusively to the Journal. Advertising rates furnished on request.

Address all communications to Business Manager, West Virginia Medical Journal, Box 1031, Charleston, West Virginia 25324. Phone 346-0551.

EDITORIALS

PERENNIAL NEED FOR PHYSICIANS

For many years the West Virginia State Medical Association has been deeply interested in the supply and demand for physicians in West Virginia. This problem, of concern to all physicians, has been discussed in the annual address of our Past President, Doctor Esposito, and is a continuing interest on the program of President Seigle W. Parks. A review of *The Journal* will show that numerous articles and editorials have examined this problem in the last ten years.

In our search for answers, let us again look closely at those factors which influence the situation. First of all, physicians are in short supply throughout the world. Although the United States enjoys a lower population-patient ratio than anywhere in the world except Israel, the supply still lags far behind the demand. The degree of scarcity varies from area to area but throughout the United States general practitioners are increasingly rare; so are specialists rare in all categories with the exception of general surgery and internal medicine.

In the United States we licensed 7,911 doctors in 1964, 6,605 of whom were United States and Canadian graduates and 1,309 were from foreign schools. In 1964, about 300 Canadian medical graduates came to the United States. This is equal to the output of three of our large medical schools in the United States. In 1965 in Great Britain alone, 621 physicians have taken the examination of the Educational Council for Foreign Medical Graduates, which is the only portal to the practice of medicine by a foreign medical graduate in the United States. This is a 20 per cent increase over the year 1964.

The State of West Virginia licensed for medical practice 102 physicians in 1964. Not all of these doctors intended to practice in West Virginia. Many of them were residents and interns. Several were only taking the examination as a basis for reciprocation to other states. In July 1965, 19 graduates of the West Virginia University School of Medicine were licensed and 6 of this group applied for reciprocity to other states before they received their diplomas.

AMA records indicate the patient-physician ratio in West Virginia at 1050 to 1, whereas in the whole United States the ratio is 750 to 1. There are, however, other types of medical services not included in the above ratio. For instance, we have over 200 foreign graduates in hospital service in this State and there are about 100 osteopaths in general practice. These additions improve our ratio to about 850 to 1.

Loss of physicians in West Virginia is in somewhat greater proportion than that of the state population loss. There is no doubt that the loss

in the professions and skills is higher than the general population decline. The loss of population and of physicians is greatest in our rural areas but this situation is not as serious as it looks at first glance. Good roads and ambulance transportation will place almost all critically ill patients within a half-hour of a hospital. The ambulant sick can ride to the nearest doctor's office. The population density in many strictly rural areas of West Virginia will not economically support a modern medical office. More emphasis should be placed in transportation of the sick to the medical center or doctor's office even if this involves some public means of conveyance.

General medical practitioners are in the greatest demand. The supply can only be developed at the source, which is the medical school. At a recent meeting of the Medical Licensing Board, 35 physicians were licensed by reciprocity. Of these, 30 were specialists and 5 general practitioners. Three of the latter group were in hospital practice and the other two were in limited practice. We are not aware of any specialist returning to general practice, but many general practitioners, after a few years of practice, take up specialty training. Sixty-five per cent of all medical freshmen profess a desire to practice general medicine but at graduation this percentage is reduced to 15 per cent. After hospital and military service the percentage is dropped to less than 10 per cent.

New fields of medicine such as industry, administration, research, pathology and others drain off many physicians from private practice. Is there any chance to reverse this trend to specialism? If there is a chance it must be developed during medical school years. Why do so many incoming students change their mind about general practice? The academic atmosphere must be responsible to some extent; some part of the blame is clearly in the lap of the medical school.

For more than two years, the WVU School of Medicine has considered the institution of a general practice preceptorship program. This system would place medical students in the close environment of a successful general practitioner for several weeks during their student training. But this program as yet is not off the ground and someone must be dragging his feet. We admit 60 freshmen to our medical school. This is a numerically inadequate source of physicians for West Virginia. If the admission class cannot be substantially and promptly increased then this Association should give consideration to the proposition of Past President Albert C. Esposito, i. e., the establishment of a two-year school of medicine in Southern West Virginia. Dr. J. B. M. Saunders, Chancellor of the California Medical Center at San Francisco, stated one month ago, "If the nation's 84 four-year medical schools would expand their enrollment by 15-20 physicians a year, this would provide a possible solution for the entire need for new physicians."

The armed forces put a greater drain on medicine than any other profession or trade. The present method of compulsory service is satisfactory to the Defense Department because it relieves the Department of the responsibility of training its own medical officers. For almost all other special services the armed forces provide in-training programs.

In West Virginia an evidence of our lack of young medical manpower is indicated by the age of our present practicing physicians. The special insurance service to our Association finds that 52 years is the average age of the medical insurees. The average time on staff for all active staff members in a representative 250-bed hospital is 19 years and the average age of the practitioner in a representative county society is 54.

We know there is no immediate solution to this problem but steps can be taken to provide for a more adequate future supply. In *The Journal* of April 1964, there was advocated a Rural Health Council patterned on the lines of an organization in Virginia which has had considerable success in meeting that state's rural problem. In Mexico, the solution is more drastic. The graduate physician is required to spend a minimum of six months in a rural community where there is no other physician. This is a requirement to be met before taking the final examination.

The West Virginia Medical Journal continues to publish on request the medical needs of any community as well as notices from physicians who are seeking desirable locations. A questionnaire will be sent shortly to all component medical societies in West Virginia asking them to list the minimal needs, location and economic status of all areas needing general practitioners and to state the number and categories of specialists required in that area.

We conclude then that our situation is not entirely hopeless; there are ways to increase the supply of physicians to meet the demand in West Virginia. But, there are no quick spectacular procedures which will do this. First steps must be taken, patience must be shown, understanding and cooperation between physician and laymen gained.

MYOCARDIAL INFARCTION IN PULMONARY EMPHYSEMA

Recently a study by Samad and Noehren[4] was reported of the incidence of myocardial infarction on 100 necropsied patients with pulmonary emphysema. The results were compared with a control group of 100 patients without emphysema. In the former group a total of 17 per cent was found to have myocardial infarction, as compared to 30 per cent in the control group. Thus, myocardial infarction apparently occurs much less frequently in patients with pulmonary emphysema than in those who are not so afflicted.

This finding seems almost paradoxical. As the authors point out, patients with pulmonary emphysema would seem more prone to developing myocardial infarction. Many of them are in the middle or older age groups, are heavy smokers, frequently have chronic hypoxia and may even show polycythemia. Obviously the pulmonary emphysema throws an additional work load on the heart.

A probable explanation seems to be that hypoxia produced by pulmonary emphysema actually increases the coronary artery blood flow. Hecht[1] has pointed out that arterial oxygen desaturation is always present in the "emphysema heart." As early as 1925 Hilton and Eicholtz[2] showed there was an improved flow of blood throughout the coronary vessels during hypoxia. Their findings have been corroborated by other workers.[3] The consensus is that hypoxia is a more powerful coronary vasodilator than preparations such as sodium nitrite, amyl nitrite, and histamine and zanthine derivatives.

Another interesting finding by Samad and Noehren was that of those patients who had infarcts 41.2 per cent were silent, whereas in the control patients who had infarcts only 20 per cent were silent. The higher percentage of silent infarcts in the emphysema patients may be explained by the fact that hypoxia dilated the coronary vessels. The increased blood flow presumably maintained an adequate circulation in the heart muscle so that the infarcts produced no subjective symptoms.

Presently there appears to be no general agreement as to the mechanism for the enhancement of coronary blood flow during hypoxia. Regardless of the exact mechanism, increased coronary blood flow during hypoxia is of great benefit to the heart.

1. Hecht, H. W.: Circulation, 14: 265, 1956.
2. Hilton, R., and Eicholtz, F.: J. Physiol. 59: 413, 1925.
3. Rose, L. B., and Hoffman, D. L.: Circulation, 4: 130, 1956.
4. Samad, I. A., and Noehren, T. H.: Dis. Chest. 47: 26, 1965.

NO SUBSTITUTE FOR UNDERSTANDING

This rather trite heading is applicable to many events which in frequent occurrence affect our profession. We refer to the apparent lack of communication between organized medicine and those who are destined to succeed us—the students in our medical schools. These young men and women are firmly contained within the ivory halls of medical education, in contact only with the influences exerted by their faculty members, and with very little knowledge of the problems they will face as medical practitioners. Most of them have little direct knowledge or understanding of the mechanics of organized medicine, a fact which is also very common among our own members.

At its recent meeting, the Council considered this matter and very wisely decided to invite representatives of the student body at the WVU School of Medicine to attend all Council meetings. An invitation will be extended to the president of the WVU Chapter of the Student American Medical Association, and he will be asked to designate another student member to accompany him to the meetings.

The experience of observing some 20 dedicated leaders who sacrifice their all-too-few hours of leisure, at their own expense, in the formulation of policy and implementation of various matters should be enlightening to our students, and will eventually be a benefit to everyone concerned.

The members of the Council are to be congratulated for their judgment and foresight in the improvement of communications and the fostering of closer relations between the medical profession and medical students.

The FDA—Inundated and Deteriorated?

The new law gave the Food and Drug Administration authority over the efficacy of drugs in addition to its original assignment, the safety of drugs. This is a responsibility that FDA was not prepared to assume. In a system of free enterprise, this responsibility belongs to the medical profession alone and not to an agency of the government. Under this new assignment, the FDA has wavered, procrastinated and quaked with indecisions on rulings which often they are unqualified to make, owing to the multifaceted areas of medical science and medical practice involved.

In addition, the volume of work has become so enormous that the staff has become inundated by its size and complexity. Time lags in getting information from the FDA have appallingly increased. The image of the FDA has deteriorated in the eyes of the pharmaceutical industry with which it is importuned to do its most vital and significant work.—John C. Krantz, Jr., Ph. D., in Military Medicine.

GENERAL NEWS

Fall Meeting of the Council In Charleston on Nov. 7

The Fall meeting of the Council was held at the Daniel Boone Hotel in Charleston on Sunday, November 7, 1965, with the Chairman, Dr. Albert C. Esposito of Huntington, presiding.

Officers and members of the Council stood for a moment of silence in memory of the late Dr. Charles L. Goodhand, who died on September 10. A Past President of the Association, Doctor Goodhand completed a term as Chairman of the Council in August and was serving as Councilor-at-Large at the time of his death.

Discontinuation of MAA Program

One of the principal items on the agenda was a report by Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Joint Conference Committee. He stated that the Department of Welfare plans to discontinue the MAA Program at the end of the fiscal year on June 30, 1966.

Doctor Weeks said that the medically indigent now receiving services under the MAA Program would be covered by the recently enacted Medicare Law. The MAA program has been in operation in West Virginia since 1960 following passage of the Kerr-Mills Bill by Congress that same year.

The decision to discontinue the program was revealed to members of the Joint Conference Committee during a meeting with Welfare Commissioner L. L. Vincent on October 27.

Third Party Programs

There was considerable discussion concerning third party medical programs in West Virginia. It was pointed out that the House of Delegates in August had approved a resolution stating that "the West Virginia State Medical Association shall approve only third party programs having service policies covering average annual income groups which pay the usual and customary fee for physician services, and that all other programs not conforming to these standards shall be considered as indemnity programs in their coverage of physicians' services."

The Council requested the Medical Economics Committee to make a careful study of all present third party fee schedules and where possible, substitute "the usual and customary physicians' fees for service in each area of the State."

Two-Year Medical School

Doctor Esposito discussed the need for additional practicing physicians in West Virginia. He recommended that a study be undertaken to determine the advisability of establishing another two-year medical school in the State.

The Council approved the recommendation and referred the matter to the Committee on Medical Education and Hospitals for study.

Closer Communications Urged

Doctor Esposito pointed out that there is a need for closer communications between the Council and the executive committees of component medical societies.

The Council went on record unanimously as recommending to the component societies that necessary action be taken to allow the Councilor of each particular district to be made an ex-officio member of the executive committee of component societies of which he is a member. In those component societies which do not have a Councilor as a member, the Council recommended that these societies should be encouraged to ask their respective Councilors to sit in an advisory capacity to the societies or to their executive committees.

The Council also recommended that a one-day County Society Officer's Conference be held in Charleston early next year. The President and members of the Executive Committee were authorized to plan the program for the meeting.

WESPAC

Mr. James S. Imboden of Columbus, Field Representative for AMPAC, was present at the meeting and discussed activities of the AMPAC and WESPAC organizations.

The Council unanimously approved a motion that an appeal be made to physicians and their wives to become members of WESPAC in order to aid the many endeavors of the organization.

Publication Committee Members Named

Dr. James S. Klumpp of Huntington was elected a member of the Publication Committee for the unexpired term ending December 31, 1966. He succeeds the late Doctor Goodhand.

Dr. Halvard Wanger of Shepherdstown was reelected a member of the Committee for the term ending December 31, 1972.

Report on White House Conference on Health

Dr. Richard E. Flood of Weirton, the President Elect, reported that he had attended the White House Conference on Health which was held in Washington, November 3-4.

Doctor Flood said that 850 persons attended the Conference and that there was lengthy discussion concerning the goals of the Administration in the field of health. He said emphasis was placed on the need for a greater number of practicing physicians throughout the country.

Medical Examiner's System

Dr. Richard W. Corbitt of Parkersburg, member of the Council and Chairman of the State Commission on Postmortem Examinations, reported that a proposed budget had been submitted to the Board of Public Works.

Doctor Corbitt said that the budget requested was the same as submitted last year and it was hoped that the Legislature would appropriate funds to implement the Medical Examiner's System, which was established by an act of the Legislature in 1963. He said that the Legislature failed to appropriate operating funds during the past three sessions.

The following members of the Council were present at the meeting: Dr. Albert C. Esposito of Huntington, Chairman; Dr. Seigle W. Parks of Charleston, President; Dr. Richard E. Flood of Weirton, President Elect; Dr. Richard V. Lynch, Jr., of Clarksburg, Vice President; Dr. Kenneth G. MacDonald of Charleston, Treasurer; Drs. Joseph L. Curry, Wheeling; Maynard P. Pride, Morgantown; Andrew J. Weaver, Clarksburg; R. L. Chamberlain, Buckhannon; A. J. Villani, Welch; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; W. F. Bittinger, Oak Hill; and Mr. William H. Lively, Secretary ex-officio and Mr. Edward D. Hagan, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston, AMA Alternate; Dr. D. E. Greeneltch of Wheeling, AMA Alternate; Dr. George F. Evans of Clarksburg, Editor, *The West Virginia Medical Journal;* Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Joint Conference Committee; and Mr. David B. Weihaupt of Chicago, AMA Field Representative, and Mr. James S. Imboden of Columbus, Field Representative for AMPAC.

Doctor Parks Speaks Before State Bar

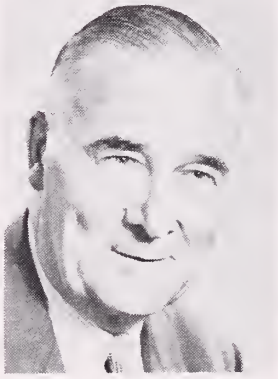
Dr. Seigle W. Parks, President of the West Virginia State Medical Association, addressed the West Virginia State Bar at its meeting in Charleston on October 22.

Doctor Parks warned the lawyers to be on guard against socialistic legislation.

"For now that we have suffered our defeat," he said, "it can be expected that the Fabian socialists will next attempt to defame other professions."

Drs. Klumpp and Wanger Named To Publication Committee

Dr. James S. Klumpp of Huntington, a Past President of the West Virginia State Medical Association, was elected a member of the Publication Committee at the fall meeting of the Council on November 7.



James S. Klumpp, M. D.

Halvard Wanger, M. D.

Doctor Klumpp succeeds the late Dr. Charles L. Goodhand of Parkersburg for the unexpired term ending December 31, 1966. As a member of the Publication Committee, Doctor Klumpp will serve as an Associate Editor of *The Journal.*

Doctor Klumpp currently is serving as Parliamentarian of the Association and Chairman of the Committee on Constitution and By-Laws. He formerly served as Chairman of the Committee on Medical Economics.

The Council also reelected Dr. Halvard Wanger of Shepherdstown to the Publication Committee for a seven-year term.

Doctor Wanger has been a member of the Committee since 1961 and was Chairman of the Program Committee of the Association for one year. He is now a member of the Program Committee and for many years has served as Executive Director of the Potomac-Shenandoah Valley Postgraduate Institute, which is held in Martinsburg each fall.

AMA Judicial Council to Sponsor Medical Essay Contest

The American Medical Association, through its Judicial Council, is sponsoring a medical ethics essay contest to be known as the Norman A. Welch, M. D. Essay Contest.

Doctor Welch died on September 3, 1964, while serving as the 118th President of the AMA. The contest will be open during this academic year to junior and senior students in accredited medical schools.

First prize will be $500. There will be a second prize of $300 and a third prize of $200.

The deadline for entries is next June 1. Contest rules are available upon request from the Department of Medical Ethics, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, or at the offices of medical school deans.

Health Department Develops PKU Test Program

A statewide program to examine all newborn children for possible Phenylketonuria is being developed by the State Health Department's Hygienic Laboratory and the Division of Maternal and Child Health, State Health Director N. H. Dyer recently reported in the "State of the State's Health."

A questionnaire is being sent to hospitals asking for information concerning their needs for assistance in such a program. County health departments are being given the same information to make them cognizant of the requirements of the program.

According to Doctor Dyer, Phenylketonuria (PKU) —an inherited metabolic disorder associated with mental retardation—is easily detected and when diagnosed early, the mental deficiency of this disorder can be prevented or favorably modified. Since PKU often involves more than one child in a family, testing can and should be done on a child of any age to alert the family and doctor of the possibility of this condition in younger siblings who could be treated. Screening of well babies is the only method of finding the first case in a family. Doctor Dyer added that approximately one child out of every four born to parents with the defective gene will be PKU-positive.

With a special low phenylalanine diet, Doctor Dyer said, PKU children detected early enough can develop as normal, healthy children. Lengths of treatment by diet must be determined by the child's physician. The diet consists mainly of fruits and vegetables low in phenylalanine. The rest of the child's protein comes in the form of a powder food from which most of the phenylalanine has been removed. Diets and recipes for various age levels are available from the Health Department's Bureau of Nutrition which can help with dietary problems associated with PKU patients.

Doctor Dyer said, "Previous testing schedules have shown that we may expect to find one PKU case in every 20,000 to 40,000 live births. Exact incidence of PKU and thus the incidence of carriers is as yet unknown. About one-half of one per cent of mental defectives in institutions are PKU-positive. The cost for each such person in a mental institution has been estimated at $100,000. This, in addition to saving a useful life, makes the PKU program more than worthwhile."

In another issue of the "State of the State's Health," Doctor Dyer reported on the State Health Department's Vaccination Assistance Project, which is engaged in the promotion of immunizations in the state against diphtheria, pertussis, tetanus, smallpox, polio, and more recently against measles.

The Project has been offering a Birth/Health Identification Card service to the parents of newborns since July. This service, aimed at motivating persons to seek needed immunizations and providing a means for maintaining individual immunization records, will follow up some 32,000 births per year. To date, 8,406 cards for newborns have been mailed and 5,177 have been returned.

Dr. Esposito Named Vice Chairman Of SMA Council

Dr. Albert C. Esposito of Huntington, Immediate Past President of the West Virginia State Medical Association, has been elected Vice Chairman of the Council of the Southern Medical Association.

Doctor Esposito's election came at the annual meeting of SMA, which was held in Houston, Texas, November 1-4.

He served as Chairman of the Senior Medical Student Committee during the meeting and is a past chairman of the SMA Section on Ophthalmology.

Dr. J. Garber Galbraith of Birmingham, Alabama, was installed as President of SMA, and Dr. Guy T. Vise of Meridian, Mississippi, was named President Elect.

Other new officers are: Dr. Oscar Benwood Hunter, Jr., of Washington, D. C., First Vice President; and Dr. Mylie E. Durham, Jr., of Houston, Second Vice President.

Mr. Robert F. Butts of Birmingham was Reelected executive director.

Dr. Milford O. Rouse of Dallas, Texas, Speaker of the House of Delegates of the American Medical Association, was presented SMA's "Distinguished Service Award."

Mrs. William G. Thuss of Birmingham was installed as President of the Woman's Auxiliary, succeeding Mrs. Jordan Kelling of Waverly, Missouri.

Louisiana State Medical Society Starts Hurricane Fund

The Louisiana State Medical Society is soliciting contributions to a fund to aid physicians whose offices and homes were destroyed by Hurricane Betsy.

"We already know of three members of our Society residing in areas below New Orleans who were completely wiped out by the hurricane," said Dr. Charles B. Odom, President of the Society. "The purpose of the Louisiana State Medical Society Betsy Fund is to assist these physicians in getting reestablished as quickly as possible."

Doctor Odom pointed out that two of the doctors affected are young men who had been in practice only a short time. Flood losses, which caused the greatest damage to the offices and homes of these physicians, are not covered by insurance.

The appeal for funds is being made only to members of the medical profession. Checks should be sent to the Louisiana State Medical Society Betsy Fund, Room 1528, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

College of Angiology Meeting

The 12th annual meeting of the American College of Angiology will be held at the Royal Orleans Hotel in New Orleans on April 20-24, 1966.

Additional information may be obtained by writing to Dr. Alfred Halpern, Secretary, American College of Angiology, 50 Broadway, New York, New York 10004.

These doctors' wives were among many who attended the Fall Board Conference of the Woman's Auxiliary to the State Medical Association which was held in Huntington, October 26-27. In left picture are (seated) Mrs. Charles H. Hiles of Wheeling, Mrs. L. Dale Simmons of Clarksburg, and Mrs. Pat Fields of Morgantown, representing the Auxiliary to the Student American Medical Association at the WVU School of Medicine. Standing: Mrs. D. E. Greeneltch of Wheeling, Mrs. M. Bruce Martin of Huntington, and Mrs. Clark K. Sleeth of Morgantown. In right picture are (seated) Mrs. C. R. Davisson of Weston, Mrs. Hu C. Myers of Philippi and Mrs. Wilson P. Smith of Huntington. Standing are Mrs. Ross P. Daniel of Beckley, Mrs. Robert J. Tchou of Williamson and Mrs. Rupert Powell of Fairmont.

Medicare Information Supplied By Social Security Office

The following information on Medicare was submitted to *The Journal* by the Social Security Administration office in Charleston:

"Benefits under the new Health Insurance, or Medicare, plan of the Social Security program will become effective July 1, 1966, but there is much to be done to get ready for the plan.

"The main task is to get everybody on the rolls who should be. Since the Health Insurance plan will affect just about everybody who is 65 or over, the Social Security Administration has the responsibility of getting in touch with them to offer them the opportunity of enrolling. Social Security has a record of about three-fourths of the people who are over 65, and there will be no difficulty in contacting them. Also, there will be no difficulty in contacting those who are receiving benefits through the Department of Public Welfare. The real job, then, is to contact those who are not on the Social Security, railroad retirement or public welfare rolls. In West Virginia this adds up to 24,600 people.

"There are two main groups which the Social Security offices are attempting to reach. One group consists of 13,800 West Virginians who are past the age of 65 and are still working. Many in this category have not had occasion to file claims for Social Security benefits, because they have continued to work and were not entitled to benefits. Although these people are still working and earning too much to receive monthly benefits, they should file a claim now. By doing so, they will automatically qualify for the Hospital Insurance benefits, and will at the same time have an opportunity to sign up for the Medical Insurance benefits.

"The other group that should be reached consists of 10,800 West Virginians who are not entitled to Social Security or railroad benefits, and who are not receiving benefits through the Department of Public Welfare or the Civil Service Commission."

50-Year Club Meeting

The Fifty Year Club of American Medicine will hold its annual luncheon during the annual meeting of the American Medical Association in Chicago, June 26-30, 1966.

Physicians who have practiced medicine for 50 years or more are eligible for membership.

Applications for membership may be sent to Dr. J. H. McCurry, Secretary, Fifty Year Club of American Medicine, Cash, Arkansas 72421. An initial fee of $5 is required to pay the cost of a lapel button, certificate suitable for framing, and a tie clasp.

AMA Congress on Medical Ethics

The American Medical Association's First National Congress on Medical Ethics and Professionalism has been rescheduled for March 5-6 at the Pick-Congress Hotel in Chicago.

The meeting had been scheduled for last October 2-3 but had to be postponed because of the special session of the AMA House of Delegates.

Physicians interested in attending the meeting should write to Dr. James H. Berge, Chairman, Judicial Council, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Doctor Parks Addresses LPNs

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was guest speaker at the 13th annual convention of the Licensed Practical Nurses Association in Clarksburg on October 7.

The title of Doctor Parks' address was: "Your Image Is Showing."

More than 100 licensed practical nurses attended the business sessions and educational and social programs. Mrs. Cinda Lou Fowlkes of Huntington was reelected President of the Association.

Pfizer Laboratories Offers Film On 1965 AMA Convention

The Pfizer Laboratories Division of Charles Pfizer & Co., Inc., is making available for group showings a 40-minute film covering the June 1965 meeting of the American Medical Association.

Called "AMA 1965," the film is a condensation of more than two hours of scientific news coverage which was filmed and videotaped during the meeting. Included are interviews with Dr. Albert S. Gyorgyi, Nobel Prize winner from the Marine Biological Laboratory at Woods Hole, Massachusetts; and Dr. John Lawrence, Director of the Donner Radiation Laboratory, University of California.

The film is available for medical societies, medical schools and other professional groups from the Pfizer Medical Film Library, 267 West 25th Street, New York, New York 10001.

135,000 Persons Are Wearing Medic Alert Emblems

More than 135,000 persons are now wearing emblems to inform others of their medical problems in case of an emergency, the Medic Alert Foundation reports.

The Foundation distributes a metal emblem that has the words "Medic Alert" engraved and emblazoned in red on one side. On the reverse side is engraved the individual's medical problem, such as "Diabetes," "Allergic to Penicillin" or "Taking Anti-Coagulants."

The Foundation maintains a central file accepting on a 24-hour basis collect calls from anywhere in the world, relaying information from the file pertaining to the wearer.

Dr. Marion S. Collins, the President, said no one is denied membership in the organization for lack of membership fees. This year, the Foundation has distributed more than 500 emblems to indigent persons.

Further information may be obtained by writing to Medic Alert Foundation, Turlock, California 95380.

Ob. and Gyn. Travel Meeting Held in Norfolk, Virginia

The annual Travel Meeting of the West Virginia Obstetrical and Gynecological Society was held at the Golden Triangle Motel in Norfolk, Virginia, October 20-23.

The meeting was held in conjunction with the District IV meeting of the American College of Obstetricians and Gynecologists.

The following West Virginia physicians attended the four-day meeting: Drs. Clarence H. Boso and Gates J. Wayburn of Huntington, Daniel A. Mairs of Charleston, A. J. Villani of Welch, Warren D. Elliott of Beckley, E. W. McCauley of Bluefield, and G. Thomas Evans of Fairmont.

A guest at the meeting was Dr. James M. Habel, President of the Virginia Obstetrical and Gynecological Society.

Gov. Smith Pledges Support For 'Project Adam'

Gov. Hulett C. Smith has promised his complete support for the West Virginia State Medical Association's program to encourage more physicians to locate in rural areas.

Earlier, Dr. Seigle W. Parks of Charleston, President of the State Medical Association, had written to Governor Smith and other leaders seeking their cooperation for the program, which is known as "Project Adam."

The Governor endorsed "Project Adam" at a news conference on October 27.

"This program has my whole-hearted support," he declared. "I would urge citizens of affected areas to contact their county medical societies about this project. And I wish to commend leaders of the medical profession for the action they are taking on this problem."

PG Course in Internal Medicine

The American College of Physicians is offering a postgraduate course entitled "Medicine of Tomorrow: Recent Advances in Internal Medicine," at the University of Alabama Medical Center in Birmingham, January 10-14.

Fees are $60 for ACP members and $100 for nonmembers.

Registration forms and other information may be obtained by writing to Dr. Edward C. Rosenow, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Symposium In Huntington

Four members of the faculty of the West Virginia University School of Medicine participated in a Medical Symposium in Huntington on November 7.

The program was sponsored by the West Virginia Chapter of the American Academy of General Practice. The speakers and their subjects were:

Dr. John B. Harley, Head of the Division of Hematology, "Multiple Myeloma"; Dr. Allen E. Yeakel, Assistant Professor of Anesthesiology, "General Practice of Anesthesia"; Dr. George G. Green, Associate Professor of Radiology, "Isotopes and Their Diagnostic Use in Medicine"; and Dr. George R. Nugent, Assistant Professor of Neurological Surgery, "Treatment of Parkinson's Disease."

Doctor Reiter Elected

Dr. Martin D. Reiter of Wheeling has been elected Secretary-Treasurer of the Pittsburgh Allergy Society.

Doctor Reiter is a member of the faculty of the University of Pittsburgh Medical School and practices allergy and internal medicine in Wheeling.

He is a Past President of the West Virginia State Society of Allergy.

10th Annual PG Institute In Martinsburg

More than 200 physicians attended the 10th Annual Potomac-Shenandoah Valley Postgraduate Institute which was held in Martinsburg, October 29-31.

Dr. Morris Fishbein, former Editor of the *Journal of the American Medical Association,* and newspaper columnist Drew Pearson of Washington were on the program along with a number of nationally known speakers on scientific subjects.

The subject of Doctor Fishbein's talk at the annual banquet on October 30 was "Medicine and the Changing Social Order."

Doctor Fishbein touched on Medicare, the increase in life expectancy, the trend toward medical specialization and scientific advances in medicine.

"Medicare is all experimental," he said. "We can make it work . . . and then correct as we go along."

He said no country has ever solved the problems of the aged and declared: "The stupidest thing we've ever done is compulsory retirement at 65."

Doctor Fishbein, 76, remains active as a writer for lay and professional publications and as a speaker and lecturer.

Doctor Fishbein also spoke on "The Bicentennial of Medical Education in the United States" during one of the scientific sessions and presided at a roundtable luncheon discussion on medical writing.

Mr. Pearson, in his address at a dinner the night before, gave a behind-the-scenes picture of official Washington. He concluded his remarks by making a number of predictions, one of which was a forecast that the United States and Russia will become semi-allies against Communist China.

Dr. Halvard Wanger of Shepherdstown serves as Executive Director of the Institute.

Drew Pearson (left), well known Washington newspaper columnist, is shown conversing with Dr. Jack Leckie of Huntington, President of the West Virginia Chapter, American Academy of General Practice, during a dinner at the 10th annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg.

Course In Infectious Diseases

The American College of Physicians will offer a course entitled "Current Concepts of Infectious Diseases," at Jefferson Medical College and Medical Center in Philadelphia, February 7-10.

Fees will be $60 for ACP members and $100 for nonmembers.

Additional information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Dr. Halvard Wanger of Shepherdstown (second from right in left photo), Executive Director of the Potomac-Shenandoah Valley Postgraduate Institute, is shown with three of the speakers. Left to right: Dr. Charles M. Thompson, Professor of Gastroenterology at Hahnemann Medical College; Dr. Seigle W. Parks, President of the West Virginia State Medical Association; Doctor Wanger; and Dr. John C. Krantz, Jr., Professor of Pharmacology at the University of Maryland School of Medicine. In right photo are Dr. Morris Fishbein of Chicago, former Editor of the Journal of the American Medical Association; and Dr. F. A. Hamilton, Jr., of Martinsburg, President of the Eastern Panhandle Medical Society.

Dr. Wilbur Named Superintendent Of Weston State Hospital

Dr. Cornelia Wilbur of New York City was appointed superintendent of Weston State Hospital, effective October 17.

Doctor Wilbur, who was in private practice in New York City, also is to receive an appointment on the faculty of the Department of Psychiatry at the West Virginia University School of Medicine.

She received B.S., M.S., and M.D. degrees from the University of Michigan and is a Diplomate of the American Board of Psychiatry and Neurology. She is the author of numerous scientific papers which have appeared in professional journals.

Mrs. Fultz Reelected President Of Nurses Association

Mrs. Josephine Fultz of Clarksburg was reelected President of the West Virginia Nurses Association during the organization's convention which was held at the Pleasant Point Resort in Point Pleasant, October 13-15.

Other officers for the coming year are: Miss Nancy Martin of Moundsville, First Vice President; Miss Cecilia Coyne of Bridgeport, Ohio, Second Vice President; Mrs. Ardenia Tully of South Charleston, Secretary; and Miss Dorothea Fee of Charleston, Treasurer.

Board members are Mrs. Rachel Collins of Elkins, Mrs. Delsia Copeland of Beckley, Sister Andrea Novak of Clarksburg and Miss Audrey Windemuth of Morgantown.

Eight State Physicians Inducted As Fellows of ACS

Eight West Virginia Surgeons were inducted as Fellows of the American College of Surgeons in Atlantic City on October 22.

New members from West Virginia are as follows:

Drs. Stephen T. J. Lee of Beckley, James P. Thomas of Bluefield, Henry R. Glass, Jr., James W. Lane and John B. Markey of Charleston, Catalino B. Mendoza, Jr., of Clarksburg, Byron M. Bloor of Morgantown and Bradford M. McCuskey of Wheeling.

The American College of Surgeons is a scientific, educational and voluntary association of surgeons numbering 26,000 Fellows in 83 countries.

Heart Symposium In Arizona

The Arizona Heart Association will conduct its Ninth Annual Cardiac Symposium in Phoenix, January 28-29.

Fees are $15 for both days and $10 for one day. Medical students, residents and interns are not required to pay fees.

Additional information may be obtained by writing to Arizona Heart Association, 2924 North 16th Street, Phoenix, Arizona 85006.

Physician Cooperation Sought In Health Project

Some West Virginia physicians will be asked to cooperate in a 4-H Club health program.

It was explained that the program has a two-fold purpose: to create awareness of existing health personnel and facilities; and to learn how to use them better.

Sometime within the next three or four months, physicians, dentists, health departments and hospital and nursing home administrators probably will receive a letter from the county extension agent explaining the program. Then a 4-H member will call and ask for an interview not to exceed five minutes.

W. Va. Heart Association Lists Officers For 1965-66

Officers of the West Virginia Heart Association for 1965-66 are as follows:

Miss Mary Virginia Slack of Charleston, Chairman of the Board; Dr. A. D. Kistin of Beckley, President; and Dr. Herbert E. Warden of Morgantown, President Elect.

Dr. James H. Walker of Charleston, Vice President; Mr. Jack L. Lewis of Bluefield, Secretary; and Miss Mary Helen Thompson of Charleston, Treasurer.

PG Course In Ophthalmology

The Cleveland Clinic Educational Foundation will present a postgraduate course in ophthalmology in Cleveland, January 12-13.

The registration fee for the course is $30. Residents and interns will be admitted to the scientific sessions without charge if arrangements are made prior to the course and if space is available.

Further information may be obtained by writing to the Education Secretary, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

The Drug Without Side Effects

There exists an unrealistic public image of drugs that there could be remedial agents with various and optium therapeutic effects without any toxicity. This is clearly utopian. The drug without side effects still remains to be discovered and it is most unlikely that it will ever be found.—Cornielle J. F. Heymans, M. D., in Georgetown Medical Bulletin.

Look at the Risk in Terms of Gain

It would appear then that the future family physician will discuss the hazards of medical therapy in advance with the patient and family much as the surgeon does at present. As medical complications become less covert, the practitioner, like the investor, the politician, or the surgeon, will have to weigh risk in terms of gain.—John F. Stapleton, M. D. in Archives of Environmental Health.

Johns Hopkins Professor Wins First Welch Award

Herbert E. Klarman, Ph. D., Professor of Public Health Administration at Johns Hopkins University, received the first annual Norman A. Welch, M. D. Memorial Award during the annual program conference of the National Association of Blue Shield Plans in Chicago on October 25.

The annual award was sponsored by the Association to honor Doctor Welch, who died in September, 1964, while serving as President of the American Medical Association. Doctor Welch was active in Blue Shield at the local and national levels for many years.

Doctor Klarman won the award for his book, "Economics of Health." The award consists of a gold medallion and a contribution in Doctor Klarman's name to the Norman A. Welch, M. D. Memorial Fund of the AMA's Education and Research Foundation.

Contest judges were Dr. Charles C. Edwards, Director of the AMA's Division of Socio Economic Activities; Dr. William H. Wehrmacher of the American Medical Writers Association; and Dr. H. Thomas McGuire of the National Association of Blue Shield Plans Board of Directors.

PG Course in Pediatrics

The Medical College of Georgia is presenting a postgraduate program in pediatrics on the Medical College campus in Augusta, January 25-26.

The program is designed to inform physicians of recently developed knowledge about diseases of children that has application to clinical patient care. The coordinator for the professional content of the course is Dr. Gerald H. Holman, Professor and Chairman of the Department of Pediatrics at the Medical College of Georgia.

Additional information may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

ACP Meeting For Internists Held In Pittsburgh

The American College of Physicians conducted a regional meeting for internal medicine specialists in Pittsburgh, November 19-20.

The meeting was arranged for internists in Western Pennsylvania, West Virginia and Ohio.

Scientific topics included detailed reports on diagnosis of different heart problems, a study of pneumoccal endocarditis at a local hospital and the evaluation of drug therapy for bacterial infections and rheumatoid arthritis.

The meeting was one of 29 scientific sessions sponsored each year by the ACP throughout the United States and Canada. Among those directing the program was Dr. Edmund B. Flink of Morgantown, ACP Governor for West Virginia and Chairman of the Department of Internal Medicine at the West Virginia University School of Medicine.

Student Essays Are Invited In Osler Contest

All candidates for the degree of Doctor of Medicine and students who graduated in 1965 are eligible for this year's William Osler Medal.

The American Association for the History of Medicine awards the medal for the best unpublished essay on a medico-historical subject written by a medical student in the United States or Canada. The medal, which was first awarded in 1942, commemorates the great physician, Sir William Osler, who stimulated an interest in the humanities among students and physicans.

Essays of not more than 10,000 words should demonstrate either original research or an unusual appreciation and understanding of a medico-historical problem. The winning essay will be submitted to the Editorial Committee of the Association, which may recommend it for publication in the *Bulletin of the History of Medicine.*

Entries must be submitted by March 23, 1966, to the Chairman of the Osler Medal Committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 East Chicago Avenue, Chicago, Illinois 60611.

PHS Announcement

The following announcement was presented to *The Journal* by the U. S. Public Health Service.

"The cooperation of physicians is requested in a continuing clinical study of calcium metabolism and calcium kinetics being conducted by the Metabolism Service, National Cancer Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland.

"Of interest for this study are patients with hypoparathyroidism, hypercalcemia of malignancy without bony metastases, Paget's diease, osteogenesis imperfecta, and idiopathic osteoporosis in males. Patients with roentgenologic evidence of bone disease as well as documented serum calcium abnormalities would be of special interest.

"Patients for this study should be clinically stable, ambulatory, continent of urine and feces, and be willing to participate in metabolic balance studies, including administration of Ca47, during a 30-day admission to the Clinical Center.

"Physicians interested in having their patients considered for this study may write to James Phang, M. D., Clinical Center, Room 3-B-40, National Institutes of Health, Bethesda, Maryland 20014."

Mental Health Meeting

The Council of State Governments and the National Institute of Mental Health are co-sponsoring a National Conference on Community Mental Health Programs in Chicago, December 13-15.

Purpose of the meeting is to evaluate state and local financing mechanisms for the support of community mental health services.

New Association Members

Dr. Curtis L. V. Adams, Appalachian Regional Hospital, Man (Logan). Doctor Adams, a native of Huntsville, Alabama, was graduated from the University of Alabama and received his M. D. degree in 1962 from the Medical College of Alabama. He interned at the Medical Center in Columbus, Georgia, 1962-63, and he was previously located in Red Bay, Alabama. He is engaged in general practice.

* * * *

Dr. Carl L. Anderson, 906 Third Street, Moundsville (Marshall). Doctor Anderson, a native of Moundsville, was graduated from West Virginia University and attended the two-year WVU School of Medicine. He received his M. D. degree in 1960 from the Medical College of Virginia. He interned at Akron City Hospital, 1960-61, and served a residency at Ohio Valley General Hospital in Wheeling, 1961-65. His specialty is surgery.

* * * *

Dr. Owen C. Meadows, Professional Park, Beckley (Raleigh). Doctor Meadows, a native of Hinton, was graduated from the University of Virginia and received his M. D. degree in 1960 from the University of Virginia School of Medicine. He interned at the University of Mississippi Hospital, 1960-61, and served a residency at the University of Virginia Hospital in Charlottesville, 1961-65. He served for three years with the United States Air Force. His specialty is obstetrics and gynecology.

* * * *

Dr. Rodolfo K. Stock, 123 West Washington Street, Charleston (Kanawha). Doctor Stock, a native of Peru, received his M. D. degree in 1956 from the Universidad Nacional Mayor De San Marcos de Lima. He interned at Glokner Penrose Hospital, Colorado Springs, Colorado, and served residencies at Kanawha Valley and Memorial hospitals in Charleston and Bethesda General Hospital. He is engaged in general practice.

PG Course In Allergy

The University of Tennessee College of Medicine will offer a postgraduate seminar on "Fundamentals of Otolaryngologic Allergy" in Memphis, March 15-19.

Further information may be obtained by writing to Wallace H. Mayton, Director, The University of Tennessee Medical Units, Department of Continuing Education, 62 S. Dunlap Street, Memphis, Tennessee 38103.

Film on Anesthesiology

A. H. Robins Company, Inc., is making available a 16 mm. black and white sound film entitled "Is There a Place for Respiratory Stimulants in Anesthesiology?"

The film runs 30 minutes and will be available for group showings. Information may be obtained by writing to Manager of Special Services, A. H. Robins Company, 1407 Cummings Drive, Richmond, Virginia 23220.

Medical Meetings

The following is a partial list of national, state and district medical meetings scheduled for the next year.

1965

Dec. 4-9—Am. Acad. of Dermatology, Chicago.
Dec. 5-7—Am. Soc. of Hematology, Philadelphia.
Dec. 7-9—Southern Surg. Assn., Hot Springs, Va.

1966

Jan. 19—Soc. of Adolescent Psychiatry, New York.
Jan. 22-27—Am. Acad. Orthopaedic Surgeons, Chicago.
Jan. 28-30—Sou. Radiological Conf., Point Clear, Ala.
Feb. 2-6—Am. Col. of Cardiology, Chicago.
Feb. 3-9—Cong. of Medical Education, Chicago.
Feb. 8-12—Am. Col. of Radiology, Chicago.
Feb. 14-18—Am. Protestant Hosp. Assn., Dallas.
Feb. 21-23—Am. Acad. of Allergy, New York.
Feb. 23—Nat. Multiple Sclerosis Soc., New York.
Feb. 28-March 3—Southeastern Surgical Cong., Atlanta.
March 4-9—Am. Assn. of Pathologists & Bacteriologists, Cleveland.
March 5-6—AMA Cong. on Med. Ethics & Professionalism, Chicago.
March 5-10—Int. Acad. of Path., Cleveland.
March 14-17—ACS Sectional Meeting, Cleveland.
March 18-19—AMA Rural Health Conf., Colorado Springs.
April 13-16—W. Va. Academy Oph. and Otol., White Sulphur Springs.
April 13-16—Am. Radium Soc., Phoenix.
April 14-16—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
April 15-17—Am. Soc. of Int. Medicine, New York.
April 18-21—W. Va. Acad. of Oph. & Otol., White Sulphur Springs.
April 18-22—ACP, New York.
April 25-28—Industrial Med. Assn., Detroit.
April 25-30—Am. Acad. of Neurology, Philadelphia.
April 25-29—Am. Col. of Allergists, Chicago.
April 27-29—Am. Ped. Soc., Inc., Atlantic City.
April 27-May 4—Maryland Med. Soc., Baltimore.
May 1-4—American Col. Ob.-Gyn., Chicago.
May 1—Am. Fed. for Clinical Research, Atlantic City.
May 2-5—Am. Col. of Ob.-Gyn., Chicago.
May 9-13—American Psychiatric Assn., Atlantic City.
May 22-27—Ohio State Medical Assn., Cleveland.
May 22-25—National TB Assn., San Francisco.
May 23-25—Am. Thoracic Soc., San Francisco.
May 30-June 1—Am. Ophthalmological Soc., White Sulphur Springs.
May 30-June 2—American Urol. Assn., Chicago.
June 2-4—American Gyn. Soc., Hot Springs, Va.
June 23-27—ACCP. Chicago.
June 24-25—Am. Geriatrics Soc., Chicago.
June 25-26—Am. Diabetes Assn., Chicago.
June 26-30—AMA Annual Meeting, Chicago.
July 7-9—Am. Med. Women's Assn., Rochester, N. Y.
July 10-14—Med. Women's Int. Cong., Rochester, N. Y.
Aug. 25-27—W. Va. State Medical Assn., White Sulphur Springs.
Aug. 29-Sept. 1—Am. Hosp. Assn., Chicago.
Sept. 8-10—Am. Assn. of Ob.-Gyn., Hot Springs, Va.
Sept. 9—Maryland Medical, Ocean City.
Sept. 20-22—Kentucky Medical, Louisville.
Sept. 23-27—Col. of Am. Pathologists, Chicago.
Sept. 23-Oct. 1—Am. Soc. of Clinical Pathologists, Chicago.
Oct. 1-5—Am. Soc. of Anesthesiologists, Philadelphia.
Oct. 10-14—ACS, San Francisco.
Oct. 16-21—Am. Acad. of Oph. & Otol., White Sulphur Springs.
Oct. 21-23—Am. Heart Assn., New York.
Oct. 22-27—Am. Acad. of Pediatrics, Chicago.

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WVU Medical Center
–News–

• Compiled from moteriol furnished by Arthur V. Ciervo, Director, Medicol Center News ond Informotion Services, Morgontown, West Virginio.

DR. Clark K. Sleeth, Dean of the School of Medicine, reported that Medical School enrollment for the current semester is up 18 per cent over the figure for the first semester of 1964-65.

There are 271 students, compared with 238 for the first semester last year. There are 61 freshmen, 63 sophomores, 57 juniors and 55 seniors, as well as 35 students enrolled in Medical Technology, a division of the School of Medicine.

Total enrollment at the Medical Center is 850. This includes, in addition to medical students, students enrolled in dentistry, dental hygiene, nursing and pharmacy.

Dr. Herm Author of Text

Dr. Robert J. Herm, Assistant Professor of Ophthalmology at the School of Medicine, is a co-author of a new text on the teaching of refraction, which was published last June.

The publication, entitled "Refraction: A Programmed Text," was written by Doctor Herm and Dr. Robert D Reinecke of the Harvard Medical School.

In the foreword, Dr. Albert E. Sloane of Harvard said the book "represents a different approach to learning; it is a 'breath of fresh air.' "

The text was used last summer by 80 physicians preparing to specialize in ophthalmology. It is now being used by residents in ophthalmology at University Hospital.

Research Grants

Dr. Michael Wilson, Chairman of the Department of Physiology in the School of Medicine, is studying the role that nerves play in controlling the flow of blood through the cardiovascular system.

Doctor Wilson, who joined the Medical School faculty last spring, is carrying on his research through an $87,207 grant from the U. S. Public Health Service. The grant runs for four years.

Doctor Wilson is looking into the possibility that certain diseases affecting the circulatory system may be caused in part by a change in nerves controlling the flow of blood.

For the tenth straight year, Dr. A. C. Higginbotham. Associate Professor of Anatomy, has received a $27,000 grant for studying "Mechanisms for Diminishing Atheromata."

The grant was made by the Heart Council of the U. S. Public Health Service.

Guest Lecturers

Dr. Robert A. Good, internationally known pediatrician, will lecture at the WVU Medical Center on December 30.

His paper is entitled "Central Lymphoid Tissue in Developmental Immunobiology," and his appearance is being sponsored by the Department of Pediatrics at the School of Medicine.

Doctor Good is Attending Pediatrician at Minneapolis General Hospital, Professor of Microbiology at the University of Minnesota.

Doctor Good received M. D. and Ph. D. degrees in 1947 from the University of Minnesota.

Dr. L. E. Casida, a specialist in reproductive endocrinology, was scheduled to lecture November 22-23 at WVU.

Doctor Casida, Professor in genetics at the University of Wisconsin, presented papers entitled "Graduate Training in Animal Science" and "Some Reproductive Physiological Problems in the Post-Partum Female."

Orthopedic Surgeons Meet

The Interstate Orthopedic Society met at the Medical Center on October 26.

The meeting attracted about 90 orthopedic surgeons from West Virginia, Eastern Ohio and Western Pennsylvania.

Principal speaker at the meeting was Dr. John H. Moe, Clinical Professor and Director of Orthopedics at the University of Minnesota. He presented a paper on "Scoliosis."

Cancer Research Seminar

The fourth in a series of cancer research seminars will be presented at the Medical Center on December 14.

Dr. George H. Wirtz, Associate Professor of Biochemistry, will lecture on "The Biochemistry of Immune Compliment."

Workshop for Nurses

The WVU School of Nursing conducted a five-day workshop in Charleston in November. The workshop represents an expansion of the School's continuing education program.

The workshop, which was conducted for about 40 nurses, was on "Leadership in Nursing Supervision and Administration."

Mr. Gearlean M. Swentzel, Director of the School's continuing education program, said the workshop is the first of three to be held in Charleston during the 1965-66 school year.

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The Month in Washington

• From the Washington Office of the American Medical Association.

FEDERAL agencies relaxed regulations for sale of Ipecac, ordered warning labels on certain antihistamines, and cracked down on two patent medicines. The Food and Drug Administration decided that ready availability of Ipecac as a poison remedy outweighed the dangers of possible misuse and placed it back on the list of drugs for sale over the counter without a prescription.

Since Ipecac was placed on a prescription-only basis in January, 1964, the American Medical Association, the American Academy of Pediatrics, and the Association of Poison Control Centers had urged that the vomit-inducing drug be returned to its former status.

Under the new FDA ruling, FDA's Bureau of Medicine told the Pediatrics group in Chicago that FDA decided it would be in the public interest to permit Ipecac to be sold over the counter in one-fluid-ounce bottles with special warnings on dangers of its misuse.

The FDA also ruled that in the future antihistamines containing meclizine, cyclizine and chloro-cyclizine must bear labels warning against use by pregnant women without medical advice. They were, however, left on the over-the-counter list. The FDA said massive doses of these drugs in test animals had produced congenital abnormalities, but there had been no evidence they have caused abnormalities in human babies.

Chas. Pfizer & Co., Inc., one of the companies that manufacture such antihistamines, protested the decision as not being "in accordance with the medical facts."

A House Government Operations Subcommittee headed by Rep. H. L. Fountain (D., N. C.) recently had criticized the FDA for its handling of these antihistamines, contending that stronger warnings were needed and indicating that they should be prescription items.

The FDA ordered a halt to the sale of Alergimist "A" and "B", widely advertised as "cures" for hayfever, bronchial asthma, migraine headaches and allergic dermatitis.

The product has been actively promoted through newspaper, radio and TV ads without having been passed by the agency as either safe or effective. The product, sold without a prescription, was being distributed by the Brunson Corporation of Miami Springs, Florida. FDA said the same concern previously distributed Allergimist (with two "l"s) until an injunction in September, 1964, was obtained against its interstate shipment.

The Federal Trade Commission ordered the J. B. Williams Co. of New York City to stop allegedly misrepresenting the effectiveness of "Geritol" liquid and tablets. The Commission ruled that Geritol television commercials and newspaper advertisements falsely represent that all cases of tiredness, loss of strength, run-down feeling, nervousness and irritability indicate a deficiency of iron and that the common, effective remedy for these symptoms is Geritol.

Geritol is not beneficial except in the small minority of persons whose tiredness symptoms are caused by a deficiency of iron or one or more of the vitamins contained in the preparation, the FTC said.

Legislation Enacted Into Law

More and farther-reaching health legislation was enacted into law this year than ever was acted upon by a previous Congress.

Medicare and the heart disease, cancer and stroke programs topped the list of such legislation enacted into law, but there also were other important new health programs authorized. Several existing ones were expanded. Approved health legislation included:

—A $787 million aid program for medical, pharmaceutical and other health schools. It authorized for the first time federal scholarships for students and operating funds for medical schools.

—A $105 million program of aid for medical libraries.

—A $250 million, three-year extension of grants for construction of health research facilities.

—Authorization of strict Federal controls on manufacture and sale of barbiturates and amphetamines.

—Requirement that cigarette packages, beginning Jan. 1, 1966, carry a health hazard warning.

—Extension of the vaccination program and expansion of it to include measles.

—Annual appropriation of a record $1.2 billion for the National Institutes of Health.

—Three new assistant secretaries of Health, Education and Welfare—one for health affairs.

—A four-year $92.5 million program of aid to municipalities for construction of garbage disposal plants and research in the field.

—Greater Federal powers in the water pollution field and $300 million to help communities build sewage plants.

—New Federal powers to control air pollution, including requirement that new autos have devices to reduce exhaust fumes.

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County Societies

CABELL

Dr. Joseph M. Farrell was elected President of the Cabell County Medical Society during the regular monthly meeting which was held at the Hotel Frederick in Huntington on October 14. Other new officers elected to serve during the coming year are as follows:

Dr. William L. Neal, President Elect; Dr. Robert W. Hibbard, Vice President; Dr. Harold N. Kagan, Secretary; Dr. John F. Otto, Jr., Treasurer; and Dr. M. L. White, Jr., Board of Censors.

The guest speaker was Mr. B. J. Killeen, Jr., District Manager of the Social Security Administration. He discussed the development of the Social Security Administration with its working mechanism, including the 1965 amendments covering physicians. He also discussed the new medicare law and there was a lengthy question and answer period.

Dr. Thomas W. Nale presented a report on the Family Planning Program under the Cabell County Health Department, and Dr. William L. Neal discussed the United Fund Campaign.

Drs. Donald P. Stacks and James T. Woelfel were elected to membership in the Society.—Harold N. Kagan, M. D., Secretary.

FAYETTE

Dr. Norman A. Desrosiers, Supervisor of Medical Services for the West Virginia Department of Mental Health, was guest speaker at the regular monthly meeting of the Fayette County Medical Society which was held at the White Oak Country Club on October 13.

Doctor Desrosiers gave an interesting talk on mental health conditions in West Virginia.

Other guests included Judge Charles L. Garvin, Jr., President of the Fayette County Mental Health Society; and Robert K. Holliday, a member of the Legislature.—W. P. Bittinger, M. D., Secretary.

* * * *

HANCOCK

Drs. Seigle W. Parks of Charleston and Clark K. Sleeth of Morgantown were guests of honor at a dinner meeting of the Hancock County Medical Society which was held at the Williams Country Club on October 19.

Doctor Parks, President of the West Virginia State Medical Association, emphasized that the component medical societies represent the basic strength of the State Medical Association. He said he is particularly interested in the needs and problems at the local level.

Doctor Sleeth, Dean of the West Virginia University School of Medicine, gave a report on the present status of the School.

Fifteen members of the Hancock County Medical Society, including Dr. Richard E. Flood of Weirton, President Elect of the State Medical Association,

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M. E. Nugent, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Hugh R. Holtrop, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Donna Bryan, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
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attended the meeting.—George S. Kosar, M. D., Secretary.

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HARRISON

Dr. L. Lewis Pennock of Pittsburgh was the guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Clarksburg Country Club on October 7.

Doctor Pennock gave an interesting talk on "Juvenile Diabetes." He is Assistant Clinical Professor of Medicine at the University of Pittsburgh Medical School and President of the Pittsburgh Diabetes Association.

More than 40 doctors attended the meeting.

Dr. Seigle W. Parks, President of the State Medical Association, spoke at the November 4 meeting of the Harrison County Medical Society, which was held at the Stonewall Jackson Hotel in Clarksburg.

Doctor Parks discussed the doctor shortage, communications between state and county societies and "Project Adam."—Paul E. Gordon, M. D., Secretary.

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KANAWHA

Gov. Hulett C. Smith addressed the 10th annual joint dinner meeting of the Kanawha Medical Society and the Kanawha County Bar Association which was held at the Daniel Boone Hotel in Charleston on October 12.

The Governor told the 250 doctors and lawyers in attendance that their professions are "the strongest allies for progress."

"Neither of you can afford the luxury of laxity," Governor Smith added.

* * * *

LOGAN

Dr. Edmund B. Flink of Morgantown was the guest speaker at the regular monthly meeting of the Logan County Medical Society which was held at the Woman's Club in Logan on October 13.

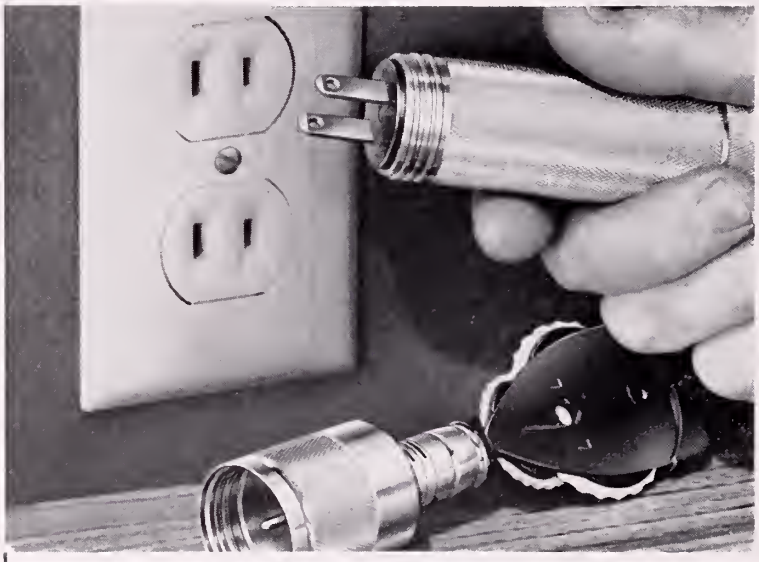
Doctor Flink, who is Professor and Chairman of the Department of Medicine at the WVU School of Medicine, presented an interesting paper on "Hyperthyroidism." His talk was illustrated by slides and there was a lengthy question and answer period.

Dr. Curtis L. V. Adams of Man was elected to membership in the Society.—Kwan Ho Lee, M. D., Secretary.

* * * *

McDOWELL

Dr. Seigle W. Parks, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at the Stevens Clinic Hospital in Welch on October 13.



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Doctor Parks discussed recent developments in the Medicare program, developments in programs under the State Department of Welfare and other matters.

Fifteen members and guests attended the meeting.—John S. Cook, M. D., Secretary.

* * * *

MARION

Dr. Seigle W. Parks, President of the West Virginia State Medical Association, was guest speaker at the regular monthly meeting of the Marion County Medical Society, which was held in Fairmont on November 3.

Doctor Parks stressed the importance of encouraging doctors to stay in West Virginia. He said a survey revealed that 76 physicians have left the state in the last five years.

* * * *

MERCER

Dr. Seigle W. Parks of Charleston, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on October 18.

Doctor Parks discussed local medical problems and ways they might be resolved.

The Society voted unanimously to make a $25 donation to AMA-ERF in memory of Dr. Charles L. Goodhand of Parkersburg, a former President of the State Medical Association who died in September.—John J. Mahood, M. D., Secretary.

* * * *

RALEIGH

The New River Dental Society, the Raleigh County Medical Society and the New River Pharmaceutical Society held a joint dinner meeting at the Beckley Elks Lodge on October 21. The dental society was the host group.

Guest speakers were Clyde Litton, M.D., D.D.S., and Wilbur C. Moorman, D.D.S., both of Charleston.

Drug Revolution in Psychotherapy

Following a decade of wide clinical use, psychotherapeutic drugs are firmly established as potent and useful therapeutic agents. These drugs have sparked a revolution in the treatment of major emotional disorders, such as schizophrenia. This tremendously disabling illness, which strikes at an early age and may last a lifetime, is becoming more amenable to treatment.

Hospital treatment of the insane, only recently a national disgrace, has now become more humane, more energetic, and, most of all, more effective, due largely to drug therapy.—Leo E. Hollister, M. D., in Clinical Pharmacology and Therapeutics.

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Corresponding Secretary: Mrs. M. L. White, Jr., Huntington
Parliamentarian: Mrs. D. E. Greeneltch, Wheeling

22nd ANNUAL CONFERENCE IN CHICAGO

The 22nd Annual Conference of State Presidents, Presidents Elect, National Officers and Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held at the Drake Hotel in Chicago, October 10-13.

Representing West Virginia were Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Pat A. Tuckwiller, a Past President and a member of the Rural Health Committee; and Mrs. Hu C. Myers of Philippi, President Elect.

Speakers included: Dr. James Z. Appel, President of the American Medical Association; Dr. F. J. L. Blasingame, Executive Vice President of the AMA; Mrs. Robert Beckley, Eastern Regional Vice President of the Auxiliary to AMA; Dr. Frederick Swartz, Chairman of the AMA Committee on Aging; and Dr. Eugene Guthrie, Chief of the U. S. Public Health Service Division of Chronic Disease.

Dr. James Telfer, Chairman of the AMA Department of Environmental Health; Dr. Fred Hein, Chairman of the AMA Department of Community Health and Health Education; Mrs. Winthrop Rockefeller, President of the National Association for Mental Health; Mrs. John Dickie, National Program Chairman; and Mrs. Asher Yaguda, President Elect of the Auxiliary to AMA.

Mrs. Herbert L. Mantz presented an interesting talk on "A-B-C's of Parliamentary Procedure."—Mrs. Hu C. Myers, President Elect.

* * * *

GREENBRIER VALLEY

Mrs. Eugene McClung of Lewisburg has been elected President of the Woman's Auxiliary to the Greenbrier Valley Medical Society.

Mrs. McClung and other new officers were elected at a meeting which was held at the home of Dr. and Mrs. Eugene J. Morhous in White Sulphur Springs on September 29.

Other new officers for the coming year are: Mrs. Robert G. Shirey of Lewisburg, Vice President; Mrs. Paul E. Prillaman, Jr., of Ronceverte, Recording Secretary; Mrs. Robert M. Ferrell of Lewisburg, Corres-

The human spine is not engineered fc prolonged sitting at desks, pianos, type writers and drafting boards. The stresse set up by the heavy, forward-tilted hea and trunk, balanced precariously on a insufficient base, result in strain of th dorsal musculature, particularly at th low lumbar level.

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One instance each of pancytopenia and leuko penia, occurring when carisoprodol was admin istered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodo and subsequent cross reaction to meprobamate Rare allergic reactions, usually mild, have include one case each of anaphylactoid reaction with mil shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy In cases of allergic or hypersensitivity reactions carisoprodol should be discontinued and appropri ate therapy initiated. Suicidal attempts may pro duce coma and/or mild shock and respiratory depression.

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ponding Secretary; and Mrs. Ernest T. Cobb of Ronceverte, Treasurer.

* * * *

KANAWHA

Members of the Woman's Auxiliary to the Kanawha Medical Society held a coffee in Charleston on October 12.

Mrs. Richard D. Kitching spoke on ways to raise money for AMA-ERF. Mrs. James T. Spencer spoke on the hearing testing program in the schools, and Miss Dorothy Brooks discussed the two-year nursing program at Morris Harvey College.—Mrs. J. L. Mangus, Publicity Chairman.

* * * *

MERCER

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the State Medical Association, was guest speaker at a meeting of the Woman's Auxiliary to the Mercer County Medical Society in October at the Y Center.

Mrs. Smith, who was introduced by Mrs. John J. Mahood, spoke on the objectives of both the state and national auxiliaries for the coming year. She emphasized the role of the local auxiliaries in AMA-ERF.

Twenty-five members and guests attended the luncheon meeting.

MINGO

The Woman's Auxiliary to the Mingo County Medical Society met at the home of Dr. and Mrs. A. H. Henderson in South Williamson on October 21.

Mrs. Sally Zando, Mingo County Health Nurse, was elected to honorary membership in the Auxiliary. She was recognized for many years of outstanding service to the medical profession in Mingo County. It was the first honorary membership ever voted by the local Auxiliary.

Mrs. L. Lake Swigart of Williamson, the Auxiliary President, presided at the meeting, which also featured a roundtable discussion of AMA-ERF.

* * * *

MONONGALIA

The regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at The Embers on October 5.

Hostesses for the dinner meeting were Mesdames D. Franklin Milam, Harold I. Amory, Carl E. Johnson, Charles S. Mahan, Justus C. Pickett, Clement A. Smith and Frederick R. Whittlesey.

Mrs. George A. Curry of Morgantown, Immediate Past President of the Woman's Auxiliary to the State Medical Association, gave a comprehensive report on the recent National Conference on Community Health Services which she attended in Philadelphia.

Mrs. Wilson P. Smith of Huntington, President of the Woman's Auxiliary to the West Virginia State

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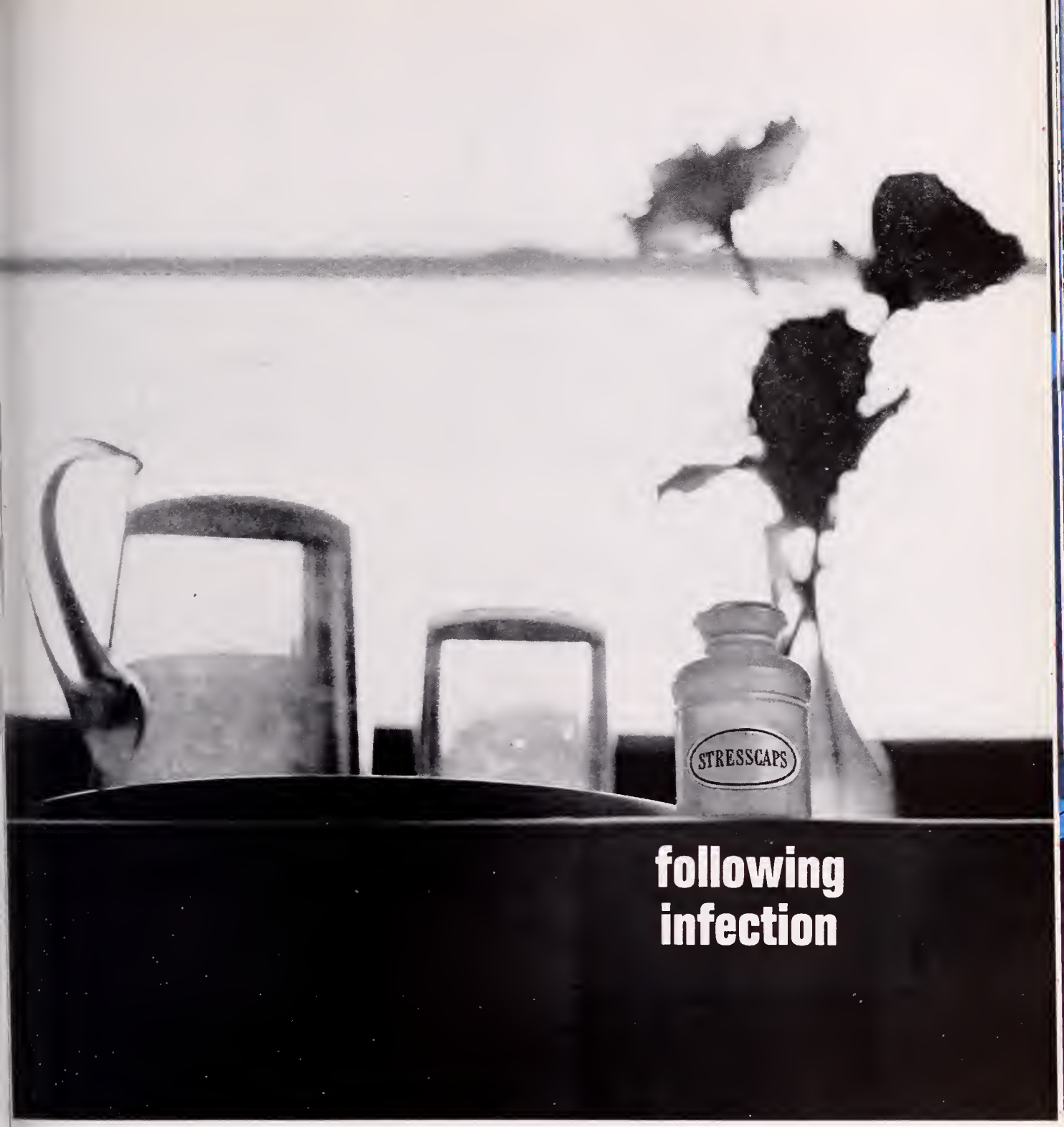

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Medical Association, was guest speaker at the November meeting of the Monongalia County Auxiliary, which was held at the Morgantown Golf and Country Club.

Mrs. Rupert W. Powell of Fairmont, Fourth Vice President of the State Auxiliary, also was a guest at the dinner meeting.

More than 30 members and guests were entertained by the Glee Club of the Second Ward Elementary School.—Mrs. Dean Goplerud, Corresponding Secretary.

* * * *

PARKERSBURG ACADEMY

The Woman's Auxiliary to the Parkersburg Academy of Medicine held its annual dues tea at the home of Dr. and Mrs. Charles W. Thacker in Parkersburg on October 17.

Mrs. Thacker was assisted by Mesdames Robert K. Fankhauser, Logan W. Hovis and Michael A. Santer.

More than 30 members and guests were in attendance.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Book Reviews

HISTORY OF MEDICAL EDUCATION IN WEST VIRGINIA—By Edward J. Van Liere, Ph. D., M. D., Dean Emeritus and Professor of Physiology, West Virginia University School of Medicine; Gideon S. Dodds, Ph. D., Professor Emeritus of Embryology and Histology, West Virginia University School of Medicine. Pp. 218, with illustrations. Published by the West Virginia University Foundation, Morgantown. Price: $6.00.

To be asked to review this book has been a real pleasure and a distinct honor. To those of us, the alumni of the School of Medicine of West Virginia University, who owe so much to the keen insight, dedicated persistence, scholarly talents and administrative leadership of Doctors Van Liere and Dodds, we now must add our deep appreciation for this most important history of the growth and development of our School.

In this text a proper monument is constructed to the living memory of such stalwarts as Drs. Hugh W. Brock, James W. Hartigan, John Nathan Simpson, Samuel J. Morris, Gideon S. Dodds, Edward J. Van Liere, and the many others who gave us the gift of medical education of the past and built the foundations for the medical education of future generations of West Virginia's doctors.

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The authors, through their long personal experience in the growth and problems of developing and maintaining a school of medicine that would meet the strictest standards for accreditation and capable of providing a sound program of medical education, have had the courage and foresight to give to us and future generations the wealth of their knowledge and personal experience. From this firm foundation of factual knowledge, our present medical educators and the medical profession can project and build a greater future for the attainment of medical knowledge and a higher degree of medical service for the citizens of West Virginia.

As the authors of this history wrote of Dr. Allen DeFoe, "His was, indeed, a courageous spirit," it is appropriate for us who studied under these two fine men to conclude—The same courageous spirit equally applies to Dr. Edward J. Van Liere and Dr. Gideon S. Dodds.—S. W. Parks, M. D.

* * * *

OBSTETRICS—By J. P. Greenhill, M. D., Professor of Gynecology, Cook County Graduate School of Medicine. Pp. 1246. Illustrated. W. B. Saunders Company, Philadelphia and London. 1965. Price: $20.00.

In this most recent edition of Doctor Greenhill's text he has enlisted the aid of 32 contributors, many of whom are outstanding, world-renowned authorities. The basic format of the text remains essentially unchanged, but the entire book has been rewritten, revised and brought up to date. Numerous old illustrations have been removed and many new ones have been added. In total there are 84 chapters.

In Part I the physiology of reproduction, pregnancy, labor and the puerperium is discussed. Part II dwells upon the pathology of these subjects. A section on operative obstetrics also is included. New additions to the text include several pages of tabulated illustrations and an outline of prenatal human development with emphasis on features that are especially convenient for estimating horizon or age.

There is more emphasis on the basic anatomy of reproduction and more details on the physiology of the placenta and fetal membranes than in the older edition. A section on fetal electrocardiography has been added and Caldeyro-Barcia and Poseiro have

History of Medical Education In West Virginia

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written an excellent chapter on the powers and the mechanism of labor. Also included are chapters on human genetics and cytogenetics.

The book is easily read and certainly should be readily available to those who practice obstetrics, be this on a limited basis or as a specialist.—Thomas R. Poole, M. D.

* * * *

CIBA FOUNDATION SYMPOSIUM—Cellular Biology of Myxovirus Infections. Edited by G. E. W. Wolstenholme and J. Knight. 1964. Little, Brown and Co., Boston. Pp. 368. Price: $12.00.

Sir Christopher Andrews who, in 1933, first isolated influenza virus in ferrets still asks the question: "What is a myxovirus?" As a partial answer, 22 contributors to this Symposium, themselves representing a major portion of the experience achieved in this area, integrate the anatomy, physiology, ecology, biochemistry, inhibition, antigenicity and genetics of myxoviruses. As biology is broad, the diversity of approaches to the study of myxoviruses presented here spans nearly the entire distance.

Even though the novice will not likely know what the von Magnus phenomenon is—a fact which the authors take for granted—he will appreciate the generally informal style of presentation. The more experienced reader will appreciate the depth of coverage achieved in this document although most of the material pertains only to influenza and Newcastle disease viruses. Reproductions of photographs clearly display the fine structure of viruses and infected cells. While a portion of the original data could have been presented in conventional periodicals, much could not have been presented with equal effort. The ideas and concepts contained in the discussions following each presentation give insights which would never appear in other media.

This Symposium will remind us that myxoviruses still form the backbone of much of our knowledge of viruses and viral diseases.—B. E. Kirk, Ph. D.

* * * *

NEW DRUGS—Published by the AMA Council on Drugs, 535 North Dearborn Street, Chicago, Illinois. 1965. Price: $5.00. Coupon for ordering the book may be found in the advertising section of the current issues of The JAMA.

New Drugs replaces and is an improvement of the AMA's previous annual volume, *New and Non-Official Drugs*. This new edition is specifically designed to make it more useful to the practicing physician. Drugs which have been introduced within the last 10 years are arranged in chapters according to therapeutic use rather than the previous classification on the basis of pharmacological activity.

Examples of these therapeutic groupings are Antibacterial Agents, Antihypertensive Agents, Coronary Vasodilators, Diuretics and Oral Hypoglycemic Agents. Each chapter begins with an introductory section which discusses the relationship of these new drugs to older drugs used for the same purpose. Concise, accurate and authoratative monographs on individual drugs are arranged alphabetically under each chapter. The monographs give the official and trade name for each drug, the structural formula, actions and uses, adverse reactions, precautions, pharmacology, dosage and preparations, supplier, and year(s) evaluated for *New Drugs*.

The members of the Council and the consultants are thoroughly objective in discussing new drugs; they call the good ones good and the bad ones bad. This is a valuable volume for the busy physician in that it makes available to him annually precise information on new drugs.—Daniel T. Watts, Ph. D.

* * * *

HANDBOOK OF PHYSICAL MEDICINE and REHABILITATION—By Frank H. Krusen, Professor and Coordinator of Physical Medicine and Rehabilitation, Temple University School of Medicine. W. B. Saunders Company, Philadelphia and London. 1965. Pp. 725. Illustrated. Price: $16.50.

Under the editorship of Doctor Krusen a textbook for the graduate physician is available for study and reference. Its philosophy is sound and its message needs a wider audience. As our welfare program increases in its cost and with its hopeless outlook, the practicing physician needs such a volume to help him give direction to his partially disabled or handicapped patient.

The scope of the volume appears nearly encyclopedic. The technical aspects are for the student or practitioner of the modality discussed—although indications are

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* * * *

RYPINS' MEDICAL LICENSURE EXAMINATIONS—By Arthur W. Wright, M. D., Professor of Pathology, Albany Medical College of Union University. J. B. Lippincott Company, Philadelphia and Montreal. 1965. Pp. 840. Price: $12.50.

The 10th Edition of Rypins covers six subjects of basic medicine and five subjects in clinical medicine. It has a new editor, Dr. Arthur W. Wright. All chapters have been revised and brought up to date. The chapters on public health and psychiatry show a marked expansion.

The material on each subject is routinely presented. The information seems to be up to date. The sections are concise and have no padding. Clinical subjects present a satisfactory review of any phase of medicine that is probably sufficient for the average medical licensing examination.

Each section is followed by a long list of questions pertaining to the subject. The questions are not too helpful for the examinee. They are old, stereotyped and the pattern of question that any crammer can readily answer.

The first chapter in the book is helpful to any examiner with the skill and time to develop questions of the objective mutiple choice type. There also are many examples in all subjects of the type of question developed by the Federated Medicine Boards.

This book is good reading for the average medical board examinee.—George F. Evans, M. D.

Books Received

NEUROLOGICAL SURGERY OF TRAUMA—Prepared and Published under the direction of Lt. Gen. Leonard D. Heaton, the Surgeon General, United States Army. Editor· Arnold M. Meirowsky, M. D. Pp. 604, with 273 illustrations and 35 tables. Available at $6.25 per copy from the Superintendent of Documents, Government Printing Office, Washington, D. C. 20402

* * * *

MANAGEMENT OF JUVENILE DIABETES MELLITUS—by Howard S. Traisman, M. D., Assistant Professor of Pediatrics, Northwestern University Medical School; Alvah L. Newcomb, M. D., Associate Professor of Pediatrics, Northwestern University Medical School. The C. V. Mosby Company, St. Louis. 1965. Pp. 147. Illustrated. Price: $12.75.

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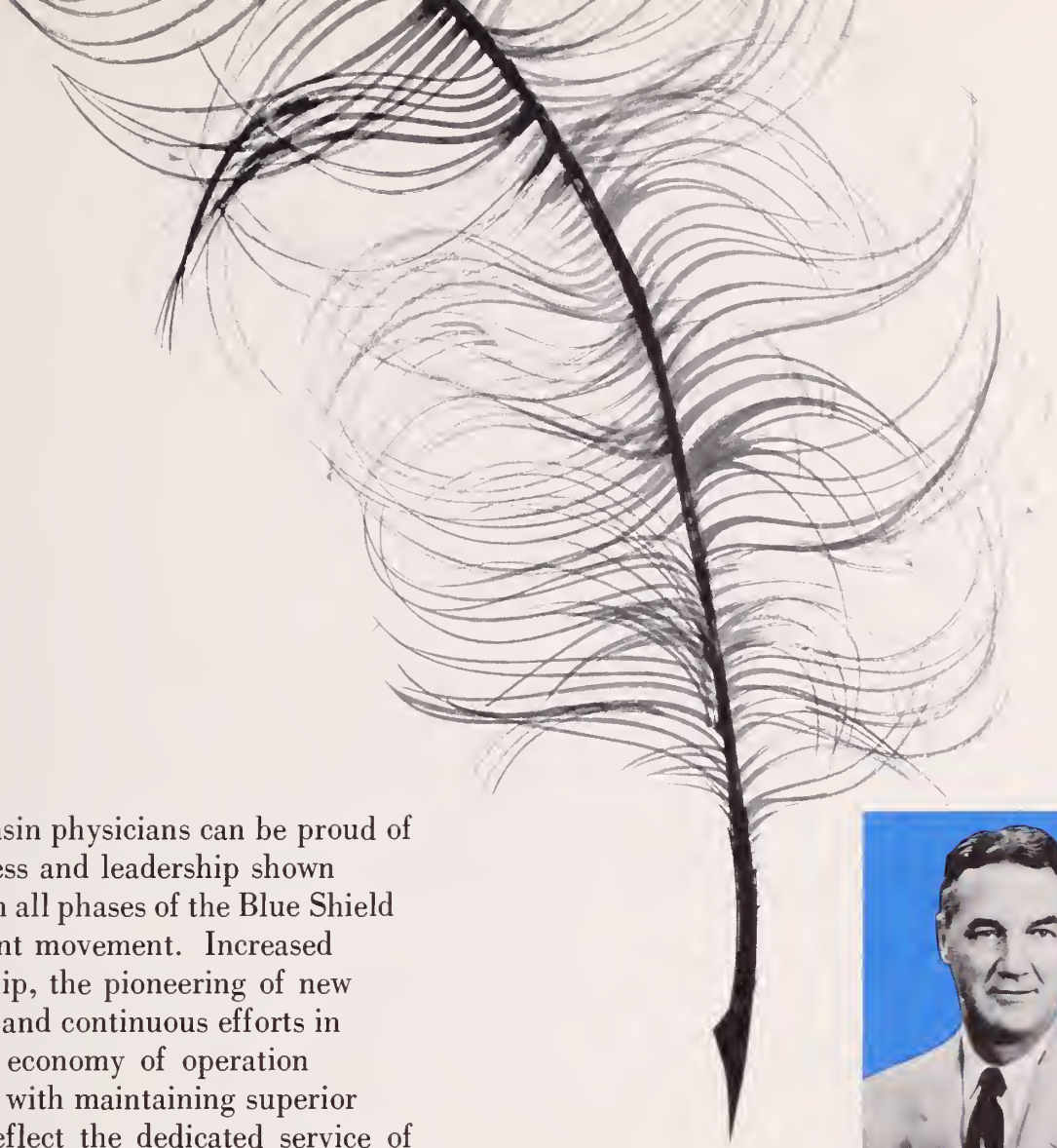
'64 PROGRESS REPOR

THE YEAR IN REVIEW

■ 1964 was a year of solid achievement for WPS, the Doctors' Plan of the State Medical Society of Wisconsin. The stated role of WPS is to pioneer in bringing the best health insurance protection possible to the people of Wisconsin, and WPS took another step in that direction by introducing the Prepaid Dental Benefit Plan, designed to make dental health insurance benefits available to locations of 25 or more employees. ■ Significant advances have also been made in the areas of improved subscriber communications and in the form of better record-keeping procedures and more prompt payment of benefits. A brief review of the following pages will clarify the progress that WPS established in 1964.



PRESIDENT'S MESSAGE

■ Wisconsin physicians can be proud of the progress and leadership shown by WPS in all phases of the Blue Shield prepayment movement. Increased membership, the pioneering of new coverages and continuous efforts in providing economy of operation consistent with maintaining superior service, reflect the dedicated service of your colleagues who are members of the Commission on Medical Care Plans.

■ WPS is "The Doctors' Plan," because physicians created and are responsible for its success or failure. It is in keeping with a "service-to-mankind" concept of medicine that doctors concern themselves . . . not only in dispensing medical care . . . but also with making sure that those needing care are not financially burdened by it.

■ The success of WPS in accomplishing these goals depends upon our continued cooperation and support.

W. P. Curran, M.D.
President
State Medical Society of Wisconsin

RENDS

Recent trends in the utilization of health e point sharply upward in most categories. ese trends are general, and reflect the added ıefits enjoyed by WPS subscribers and ›endents. This situation, however, has re- red a readjustment of WPS premiums to intain the sound reserves which will guaran- future WPS benefit payments. ■ Earned ›miums of $15,358,517 as of December 31, 54 were $2,120,000 higher than the total 1963. Rate increases were put into effect ring the second half of 1964 and should ıtinue to keep WPS reserves at a level need- ed to ensure WPS stability. ■ Along with the increase in premiums, subscriber benefit levels were also improved, reflecting increasing public awareness of the advantages of WPS protection. Benefit payments increased approximately 20% over 1963. ■ An average of almost 95 cents of each premium dollar was returned in benefits during the first six months of 1964. However, benefit payments were stabilized during the last half of the year, resulting in a final benefit ratio for the year of 90 cents of each premium dollar.

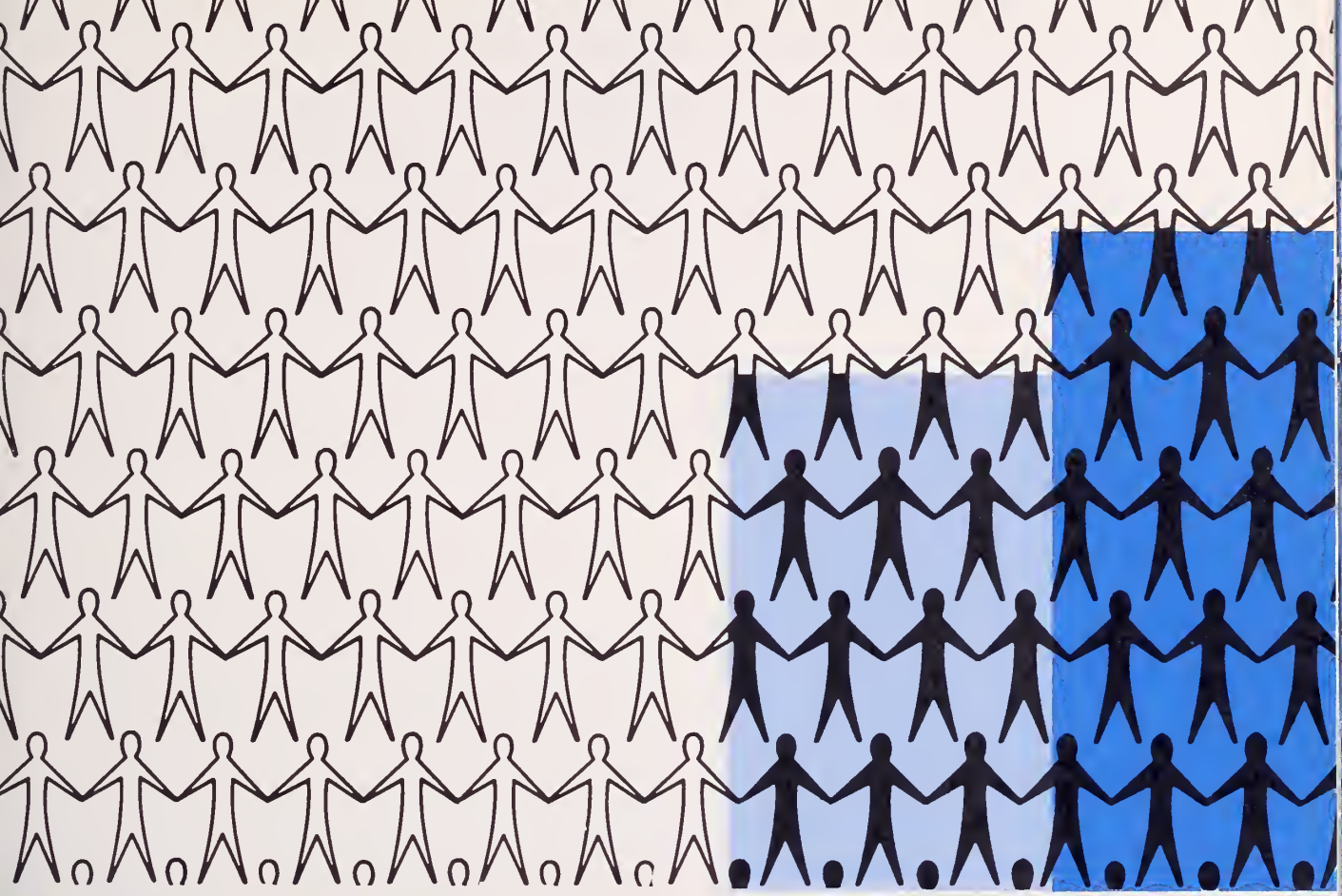
■ During 1963, the number of claims totaled 182,030, an average of 15,169 per month. In 1964, the number of claims handled increased to 211,189, a monthly average of 17,593. ■ Claims are normally processed more quickly than ever before and are paid more often . . . four times a month. ■ Further processing efficiency, in spite of the ever-increasing volume of claims processed, should result from the forthcoming transfer of many claims-handling functions to the new WPS computer system.

CLAIMS

ENEFITS

WPS shares the motivating interest of erican industry in providing the best possi- product to the consumer. ■ The primary l of WPS is to transform subscriber pre- ıms into the best benefits that money can . Beyond the initial consideration of what centage of premium is returned in benefits he primary consideration of the type and lity of service provided. This is the true ısure of how much the subscriber is getting for his premium dollar. ■ Each year, a portion of subscriber premiums is set aside in a reserve to offset fluctuations in current benefit payments and as pre-payment for new medical benefits which will be available in the future. ■ Over the years WPS has been able to direct an ever-increasing number of dollars into its "product," which is the finest in health care services for WPS subscribers.

1960	1961	1962	1963	196
,795,996				
,681,516				
,468,532				
,094,627				
973,510				



ENROLLMENT

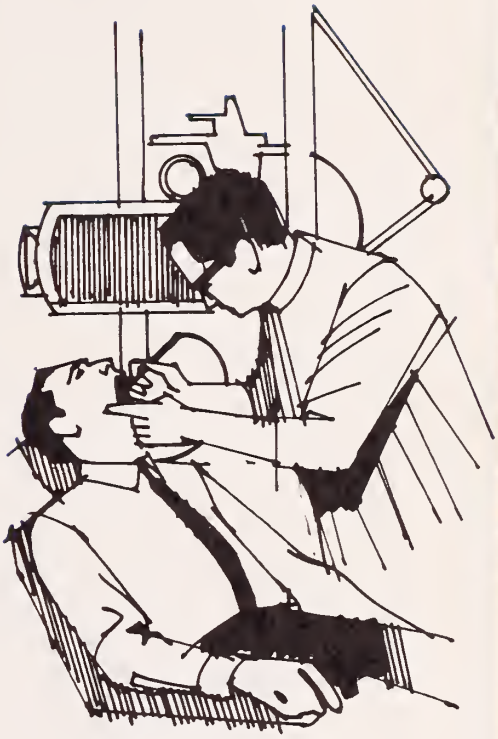
1963	1964
218,345	241,430

■ In addition to greater use of benefits by subscribers, enrollment has also expanded substantially. 241,430 contracts were in force December 31, 1964 compared to 218,345 on December 31, 1963. ■ This increase of 23,085 contracts indicates a solid growth rate of 10.6% for the year. ■ During 1964, large groups such as the State of Wisconsin employees, General Motors, American Motors and Wisconsin Telephone Company renewed their WPS contracts and many WPS groups continued to increase their protection by adding optional benefits. Successful sales efforts continue to improve subscriber benefits, particularly in upgrading many subscribers from the "B" and "A" Schedule to the Special Service, "customary, usual and reasonable" fee contract. ■ The result is an improved level of WPS benefits available throughout Wisconsin. Efforts will continue in the direction offering Major Medical protection to grou and individuals. ■ A concrete measure of su scriber satisfaction is manifested by the p sistency that subscribers demonstrate in c tinuing their WPS protection. Consider the rapid changes in employment, deaths, a transfers from the State, the monthly renew rate demonstrates an extremely high deg of subscriber loyalty. ■ The Commission Medical Care Plans concept of providing hea care to senior citizens through private initiat is receiving continued impetus and emphas The number of Century Plan subscribers creased from 13,162 on December 31, 19 to 15,029 on December 31, 1964. This crease of 14% includes the growing numl of employees who are eligible to choose C tury Plan benefits when they retire.

IMPROVED LOCAL SERVICE

■ In our effort to provide better service throughout Wisconsin, WPS has been active in developing local agents. WSP plans and services are now offered by approximately 185 local agencies located in many of the small and medium size cities in Wisconsin. ■ Vigorous efforts are also being directed toward establishing leading agents in the highly populated urban and suburban population centers.

NEW COVERAGES



■ New Major Medical plans, the Prescript Drug Benefit Plan and the Prepaid Dental B efit Plan have been recently introduced WPS, reflecting continued WPS public se ice responsibility in maintaining its leadersl in the health insurance field. ■ The most cent policy developed is the Prepaid Den Benefit Plan first marketed by WPS duri 1964. Many WPS groups indicated interest dental health insurance which indicates a tential market for this type of coverage. Dentists are included in all informational m ings to keep them informed of WPS activit in the dental health insurance field and to courage their cooperation and assistance. The Prescription Benefit drug contract, m keted in 1963 via direct-mail, is continua promoted by the same method, as well through local agents and group representativ

EDERAL EMPLOYEE PROGRAM

Federal employees in Wisconsin may par-pate in the government-wide Federal em-yee health insurance program. Of the ployees for which WPS assists in adminis-tion, 90% are protected by the high-level nefit option compared to the national cover-of 86%. ■ Of the 21,185 Federal em-yees in Wisconsin, 10.188 are protected by ie Plan coverage. Physicians' claims for vices should be forwarded to WPS on the ular WPS Physician's Service Report.

REGIONAL SERVICES

■ The Department of Regional Services of the State Medical Society is of continuous assistance to WPS. Representatives keep physicians and subscribers informed about the provisions of the Special Service Plan, a well as other details concerning participation in WPS and in the Wisconsin Plan. Field service representatives are also called upon to provide up-to-date information to administrative assistants and others concerning WPS contracts and administrative procedures.

ADMINISTRATIVE PROGRESS

■ Preparations for converting WPS operations to computer methods began in 1963. ■ An IBM 1440 Computer System was installed in January, 1964. ■ The IBM 1440, a business information and accounting system, has the following components:

1. CONSOLE

Special console lights indicate operating conditions of the processing unit, disk storage drives, the card read punch and the printer.

2. PROCESSING UNIT

Contains the magnetic core storage unit and the logic and arithmetic units that control the entire system. The processing unit can store 12,000 characters of information, thus providing the 144 powerful data handling ability.

3. DISK STORAGE DRIVES

Reads or writes 3 million characters on magne disks which resemble phonograph records. Av able disk packs can provide instantaneous access 180 million characters of information.

4. CARD READ-PUNCH

Provides card input and output. IBM cards read at speeds up to 400 per minute by light bea and are punched at speeds up to 250 cards minute.

5. PRINTER

Prints information at a speed of 600 lines minute.

ISTRIBUTION
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RESERVES .5¢

INVESTMENT INCOME

■ During the year ended December 31, 196 investment receipts contributed $220,071 WPS total income available for benefits. Th compares to $186,311 for the same period 1963 — an increase of 18.1%. This increa is the result of constant efforts to improve i vestment yield by maximizing the percenta of total WPS resources productively investe

RESERVES

■ A considerable amount of reserves is nece sary to preserve the financial stability of a insurance enterprise. WPS has maintained firm reserve position for this reason. ■ Durin the first six months of 1964, reserves prove to be the needed stabilizing factor to meet hig er than anticipated benefit payments. Reserv enabled WPS to pay out 95 cents in benefi for each dollar of premium received. ■ Ratin adjustments begun in 1964 have balanced pr mium income with benefit payments and wi maintain a firm reserve base for 1965 oper tions. The following is a summary of statistic information for 1964:

1964

TOTAL INCOME	$15,578,588
SUBSCRIBER BENEFITS	$13,795,996
ADMINISTRATIVE EXPENSE	$1,709,772
TO RESERVES	$72,882

A LOOK AT THE UTURE

The future of WPS depends upon our ability to foresee ture challenges that will soon become real and in ed of solution. ■ The Commission on Medical Care ans is charged with the responsibility, both to e public and to practicing physicians, of preparing day to meet the prepayment needs of tomorrow. ■ Your rsonal help is of continuing importance, both to ert your Commission to today's problems and to e needed development in new areas of medical care which there is professional and public interest. ■ I am nfident of the continued interest and suport of isconsin physicians.

E. M. Dessloch M.D.

E. M. Dessloch, M.D.
Chairman, Commission on Medical Care Plans

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Postgraduate Education Programs
Disability Income Protection
WPS Health Insurance
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Life Insurance
Physician Placement

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Physician Location Service
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COMPOSITION:	In each 5cc of syrup
Phenylpropanolamine Hcl	12.5 mg.
Pyrilamine Maleate	6.25 mg.
Pheniramine Maleate	6.25 mg.

INDICATIONS: This syrup combination offers immediate synergistic relief from the symptoms of nasal congestion; profuse, watery, nasal secretion, and post-nasal drip associated with common colds, sinusitis, and nasal allergies.

DOSAGE: Children—six years or over—One teaspoonful three times daily for 3 days.

CAUTION: Drowsiness may occur. Use only with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

SIDE EFFECTS: Drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness, or gastrointestinal upsets may occur occasionally.

SUPPLIED: Pints and Gallons

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RESIDENCIES AVAILABLE—Resident positions still available in the following: First and third year positions of a fully accredited four-year General Surgery Residency; first year position in Internal Medicine of a three-year program; first year of a two-year Pediatric Residency; and first and second year of a three-year Obstetric-Gynecology Residency. Phone or write to the Director of Medical Education, Memorial Hospital, Charleston, W. Va.

AVAILABLE—Physician interested in general practice, including some pediatrics, Ob., E.N.T. Community must have hospital. Graduate of WVU School of Medicine. Internship and GP residency at Charleston Memorial Hospital. Will be available in August 1966 upon completion of military service. Interested in private practice and sharing night call. Age 30. Married and one child. Contact RBJ, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

AVAILABLE—Office space for a physician in modern building in St. Albans, W. Va.; 9,000 square feet available immediately. Phone 727-6834 in St. Albans or 346-9657 in Charleston.

WANTED—General Surgeon for private hospital. Some general practice. Can net $36,000 or more. Call collect 239-2331, Logan, West Virginia.

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IMMEDIATE SALE: Established orthopedic practice, greater Charleston area. Gross $60,000 annually. Will discuss any terms. Contact ORT, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

WANTED—General practitioner, pediatrician, internist and board certified surgeon for community on Ohio River. New 40-bed hospital in industrial community. Write RAO, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—Two general practitioners to locate in the vicinity of Hundred, W. Va., which includes a large area and good advantages. Write Mrs. Mary Mike, Route 1, Burton, W. Va.

WANTED—Elderly physician to live in small hospital in pleasant community. Minimum professional duties. Write OAR, The West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

FOR SALE—Office equipment including fluoroscope, basal metabolism, electrocardiograph and other equipment. Physician retiring from practice. Write BAC, The West Virginia Medical Journal, Box 1031, Charleston, W. Va.

WANTED—Two general practitioners and a pediatrician to locate in a rapidly growing and extremely progressive community; excellent recreational facilities; within driving distance of the larger metropolitan areas; modern 45-bed general hospital, fully equipped and staffed; qualified general surgeon in residence. Write HRL, The West Virginia Medical Journal, P. O. Box 1031, Charleston, W. Va. 25324.

WANTED—General practitioner to locate in West Liberty, W. Va. Located 12 miles from Wheeling. West Liberty is the site of West Liberty State College and six miles from Bethany College. Population approximately 600 plus surrounding territory. There are sites available for doctor's office. Write Mrs. Harold F. Daugherty, Box 62, West Liberty, W. Va. Phone 336-7700.

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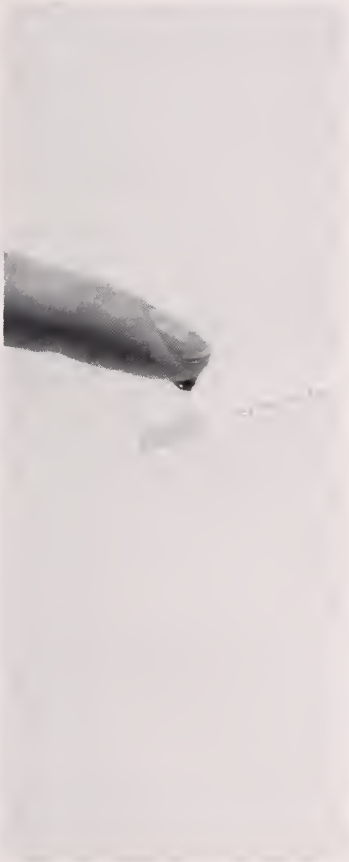

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Vol. 61 No. 12

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DECEMBER 1965

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